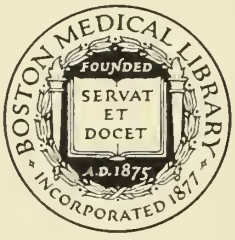
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The Ohio State
MEDICAL JOURNAL

JANUARY 1970
Vol. 66 • No. 1

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

MEDICINE'S MESSAGE to a Lay Audience

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Your Choice in Ohio of Continuing Education Courses
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What Can We Do to Shorten Postoperative Hospital Stay? See Page 41 for One Surgeon's Answer

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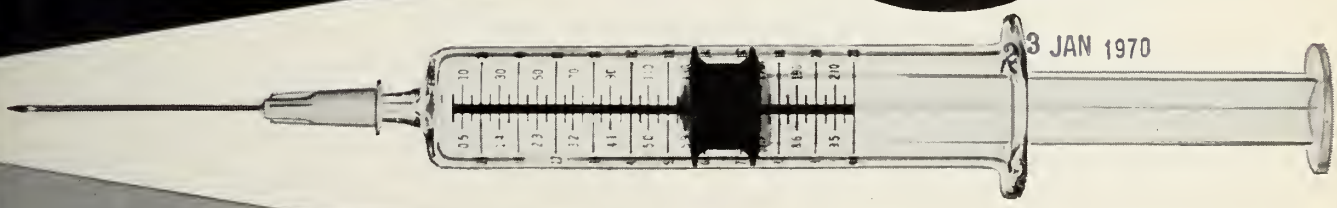
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The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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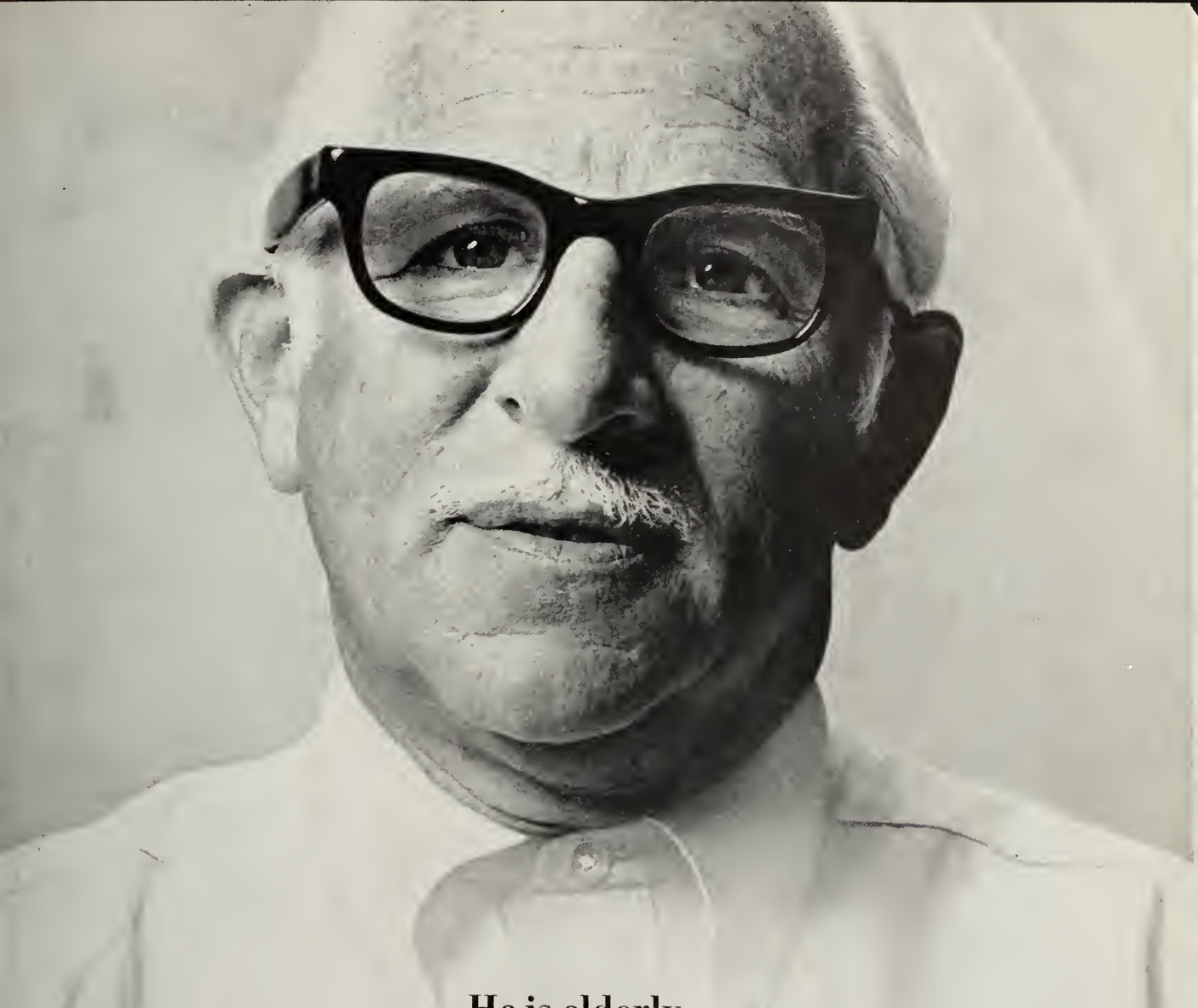
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autions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

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Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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Criticism, Paradoxes, and Hernias

Girl watching and baseball are rapidly being replaced as the national pastime by the grand old game of criticizing people who perform services for other people. Practicing physicians have not been neglected in this regard. The constant cacophony of criticism comes from sources ranging from editorial writers, columnists, and TV comedians to labor leaders, politicians, hospital administrators, and physicians who have spent their entire careers in institutional activities. Indeed, we practitioners probably criticize each other more than any other group with the possible exception of politicians in an election year.

Now, criticism can sometimes be healthy and stimulating, but it can also produce or highlight paradoxical situations. One such situation has to do with the popular contentions that we are at least partially responsible for the high cost of medical care and that our traditional methods of serving our patients are outmoded and inefficient. (Please note that I did not use that chilling bureaucratic language, "delivery of medical services.") The paradox is that, in this atmosphere of constant derogation, physicians have greatly reduced the length of hospital stay while improving the morbidity and mortality rates among many types of patients.

In the not too distant past, you will recall that women, even the multiparous with uncomplicated deliveries, spent seven to ten days in a hospital bed, went home by ambulance, and continued their convalescence for another week or so, while grandma or a nurse-housekeeper managed the household and the baby. Now, the rule is: get out of bed on the first postpartum day, walk from the elevator to the family car to ride home on about the third day, and get back to duty after a few more days at home.

The average hospital stay of a patient with uncomplicated myocardial infarction nowadays is about 2½ weeks compared with the four to six weeks of two decades ago. To be sure, the first few days of intensive care in the coronary care unit are expensive, but the hospital mortality rate of such patients has been cut very nearly in half by this expensive, intensive care!

Perhaps the greatest saving of hospital days and increase in efficiency of care has been effected by the surgeons in patients requiring elective surgery. Here, the practitioner is quite clearly and directly responsible for the improvements. In cataract surgery, for example, it's up on the evening after surgery and home in about one week. What's inefficient or wasteful about that compared with the three weeks of hospital bed rest, with all the attendant risks and complications, and the additional several days of convalescence at home that prevailed only about 15 years ago? Similar comparisons could be made for patients undergoing many other elective operations — appendectomy, cholecystectomy, prostatectomy, many orthopedic and neurosurgical procedures, and last but not least, herniorrhaphy.

On page 41 of this journal, Dr. Jack Tetirick evaluates the postoperative hospital stay of patients undergoing inguinal herniorrhaphy. This concise paper is based upon his personal experience with patients in various community hospitals. While the concept of early rising, ambulation, and discharge is not new, he makes a few points that are applicable in principle to other surgical procedures and even to some medical situations. First, it is possible to predict that, if complications are not evident by the morning of the third postoperative day, they are not likely to occur thereafter, and the patient can be discharged that day. However, the patient and his family might resist such early discharge if they have not been clearly informed in advance that discharge might be expected as early as the third day.

Applying these principles to a patient suffering myocardial infarction, for example, he and his family might, when they are informed of the diagnosis, be given a tentative timetable such as the following: assuming no complications, up in

a chair and bedside commode on the second day; out of the coronary care unit in seven (plus or minus three) days; progressively longer periods in the bedside chair until the tenth to 14th day; ambulation with bathroom privileges thereafter; discharge on the 15th or 16th day; about one month of additional convalescence on one floor at home; and progressive increase in physical activity over the next three to six weeks, aiming for return to work 2½ to 3 months after the onset.

In addition to the benefits accruing in terms of shortened hospital stay and diminished morbidity, such a tentative schedule should help the patient and his family to assume a positive attitude toward his illness and convalescence. It should be evident even to our severest critics that this can best be achieved by a confident physician, who knows and understands the patient, his family, and the environmental variables that might affect his schedule. This implies, to me at least, a one-to-one relationship based upon mutual trust and understanding, but we are told that such relationships are inefficient and archaic. See how the paradoxes accumulate?

Policy Change Announced Regarding Hill-Burton Programs

Following is the text of a memorandum regarding Hill-Burton programs issued under the subject "Policy Change."

"To: All Applicants for Hill-Burton Assistance, Areawide Comprehensive Health Planning Agencies and all other interested parties

"From: William S. Wolfe, Chief, Division of Medical Facilities, Ohio Department of Health

"The U. S. Public Health Service has adopted a new policy with respect to the use of Hill-Burton funds appropriated for fiscal year 1970. No proposed health facility construction project will be approved, for Hill-Burton assistance when any part of the project, upon completion, exceeds the area's known needs, as determined by the appropriate State Hill-Burton plan. This means that fractional projects of this type will no longer be allowed."

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face m minimized by withholding dietar salt, reduction in dosage or use diuretics. In elderly patients and in those with hypertension the d should be discontinued with the pearance of edema. The drug ha been associated with peptic ulc and may reactivate a latent pept ulcer. The patient should be instructed to take doses immedial before or after meals or with mi minimize gastric upset. Drug ra occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative der

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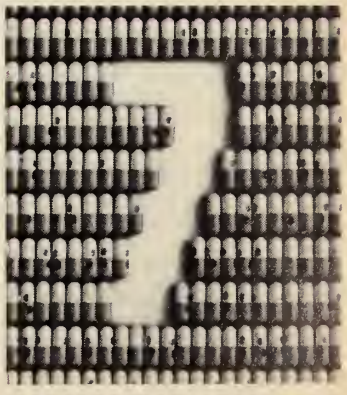
Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings and contraindications. Read the prescribing information. It's summarized below.

tevens-Johnson syndrome, syndrome (toxic necrotizing molysis),or a generalized c reaction similar to serum ss may occur and require nent withdrawal of medica- granulocytosis can occur nly in spite of regular, repeated l white counts. Stomatitis arely, salivary gland enlarge- may require cessation of treat- Such patients should not e subsequent courses of the Vomiting, vertigo and languor ccur. Leukemia and leukemoid ons have been reported. While finitely attributable to the a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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And Dulcolax works so predictably that the time of bowel movement can often be predicted. Tablets taken at night usually produce a bowel movement the following morning. Suppositories generally work in 15 minutes to an hour.

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Dulcolax suppositories may be particularly helpful when straining should be avoided, as in postoperative care. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

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Navymen and Marines Honored by Vietnam



Off the coast of Vietnam, a 19-gun salute is sounded for Prime Minister Tran Thien Kheim as he arrives aboard the amphibious assault ship USS New Orleans for the Eighth Vietnamese Awards ceremony. Steaming in the background is the dock landing ship USS Thomaston.

Fifty-nine U.S. Navy and Marine Corps personnel were decorated by the Republic of Vietnam at the Eighth Vietnamese Awards Ceremony aboard the amphibious assault ship USS New Orleans (LPH-11) at sea off Danang.

Representing the Republic of Vietnam at the ceremony were Prime Minister Tran Thien Khiem and numerous other high ranking government officials.

In the official U.S. Navy party were Admiral John J. Hyland, USN, Commander in Chief, U.S. Pacific Fleet, and Vice Admiral William F. Bringle, USN, Commander, U.S. Seventh Fleet.

Prime Minister Khiem, Minister of State Dr. Nguyen Tien Hy, and Vietnamese Navy Chief of Naval Operations Commodore Tran Von Chon presented medals to the 46 officers and 13 enlisted men.

An additional 591 awards were presented in absentia to Navymen and Marines who were unable to attend the ceremony either due to operational commitments or because they had departed the area.

After the awards had been presented, a special amphibious demonstration was held for the guests.



Navy Captain Roland W. Jones, Jr., of Newark, Ohio, is decorated by the Republic of Vietnam's Minister of State, Dr. Nguyen Tien Hy. Captain Jones was awarded the Navy Distinguished Service Order Second Class by the Republic of Vietnam for his work as the Ninth Marine Amphibious Brigade's chief surgeon. A graduate of Ohio State University College of Medicine, he is the son of Dr. and Mrs. Roland W. Jones, Sr., of Newark.

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Cordran® Tape

Flurandrenolone Tape

The steroid is right in the tape!

Lilly

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Remarkably effective...



Response of patient treated with strip of Cordran® Tape (Flurandrenolone Tape) applied to arm.

Enthusiastically received...



Protects skin from scratching or other external irritants



Practically invisible. Makeup can be applied over tape for total masking.



Easy to apply



Partially masks condition being treated

Of course, it is recommended that Cordran Tape be reserved for cases in which the benefits of its special features outweigh a possibly higher incidence of adverse reactions.

Description: A transparent, inconspicuous, plastic surgical tape, pervious to moisture, slightly elastic and highly flexible. The co costeroid flurandrenolone is uniformly distributed, 4 mcg./sq. cm. the adhesive layer.

The adhesive is a synthetic copolymer of acrylate ester and acry acid, free from substances of plant origin. A paper liner perm handling and trimming before application.

Action: Cordran® (flurandrenolone, Lilly) has anti-inflammatory, a pruritic, and vasoconstrictive actions. The tape serves as both vehicle and an occlusive dressing.

Indications: For adjunctive therapy of chronic recalcitrant derm toses responsive to topical corticosteroids, particularly dry, scal localized lesions. These include atopic dermatitis, contact dermati eczema of hands and feet, lichen planus, lichen simplex chronic neurodermatitis, nummular eczema, psoriasis, seborrheic dermati and stasis dermatitis.

Cordran Tape should be used only when its special features outwe a possibly higher incidence of adverse reactions.

Cordran is recommended as a supplement to other preparations the management of skin lesions. It may be used for symptoma relief until contributing factors are corrected. In contact or aller dermatitis, remove the offending contactant or allergen. Take a ca ful history, including a study of environmental contacts and use drugs.

Contraindications: Chickenpox, vaccinia; patients with a history hypersensitivity to any of its components. Not recommended lesions exuding serum or in intertriginous areas.

Warning: ***Usage in Pregnancy***—Although adverse effects on pr nancy have not been reported, safety of the use of topical co costeroids on pregnant women has not been absolutely establish Do not use extensively on pregnant patients in large amounts or prolonged periods.

Precautions: If irritation develops, discontinue the product and in tute appropriate therapy.

In the presence of infection, use appropriate antifungal or antib terial agents. If a prompt response does not occur, discontinue corticosteroid until the infection is adequately controlled.

If extensive areas are treated, take suitable precautions against possibility of increased systemic absorption. Exercise particular c with infants and young children.

Adverse Reactions: The following local adverse reactions have b reported with topical corticosteroids, with or without occlusive dre ings: burning sensations, itching, irritation, dryness, folliculitis, hyp trichosis, acneform eruptions, and hypopigmentation.

The following may occur more frequently with occlusive dressi than without: maceration of the skin, secondary infection, s atrophy, striae, and miliaria. In addition, the tape may cause purp and stripping of the epidermis.

Administration and Dosage: ***Preparation of the Skin***—Shower or baths should be completed before Cordran Tape is applied. Ge clean area to remove scales, crusts, dried exudates, and previou used ointments or creams. A germicidal soap or cleanser will prev the development of odor under the tape. Shave or clip the hai allow good contact and comfortable removal. Dry the skin bef applying tape.

In most cases, the tape should be replaced after twelve hours. W the skin and allow it to dry for an hour before reapplying the ta When necessary, the tape may be used only at nighttime. Loose e or corners may be trimmed off and replaced with fresh tape.

Directions for the patient are included in each package.

How Supplied: Each roll of Cordran® Tape (flurandrenolone ta Lilly) is 7.5 cm. (3 inches) wide and 200 cm. (80 inches) long.

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MEDICINE'S MESSAGE TO

A Lay Audience

William J. Lewis, M.D., Dayton

Editor's Note: Phyicians are called upon frequently to speak before lay audiences. Circumstances obviously dictate the subject matter as well as the approach. Here is an excellent example of a forthright and candid presentation in which the speaker relates to his audience. The article is based on the text of a presentation before the Ohio Petroleum Marketers Association, Inc., at its fall meeting in Columbus. Dr. Lewis is chairman, OSMA Committee on Legislation, an alternate delegate to the AMA, and vice-chairman of the Board of Directors of the Ohio Medical Political Action Committee.

MANY OF THE WORLD'S PROBLEMS are those of communications. That is one of the reasons I am here tonight—our communications have suffered severely. We find in many instances the people whom we would expect to be our natural allies and whom we would expect to understand our problems and our reactions to governmental interference are all too often actively siding with those who seek to control all aspects of our society, or at best passively siding with them by their thunderous silence.

I am the first to admit that medicine has long been one of the leaders in the let's-not-get-involved race, but hopefully we have turned the corner. So tonight, we will play the game of first you listen to my troubles and then I'll listen to yours. We will all find out that they are the same, differing in semantics, but little if any in principle.

We hope that you will make an honest attempt to understand our positions in matters relating to health. And, if we seem to be brewing tempests in teapots about such matters as free choice of physician, direct billing of patients, and reasonable and customary fees, we ask you to understand that we are trying to take a stand for individual freedom and choice, and are resisting government regulation by a governmental bureau —regulations that are in many cases far from the intent of the laws duly passed by legislative bodies.

Although they may seem to be far removed, our problems in these matters are your problems. For if there are no voices raised in dissent now, there will be nothing to stop the same thing, in a different time and manner, from happening to you.

AMA Triggers Reactions

First, let me say a few words about that much maligned body, the AMA. These are letters that are guaranteed to immediately inspire editorial writers all across the country to the heights of journalistic invective and sarcasm, accompanied by great wailing, gnashing of teeth, and the pouring of ashes over collective liberal heads. We find ourselves in a rather unique, albeit unenviable position of having a lousy collective image and, by and large, a rather good individual image.

Ask most any citizen what he thinks of doctors generally and the AMA in particular and you will likely hear a rather negative opinion. Ask him what he thinks of his own doctor—which is usually the only one he knows—and more often than not he will say, "He's different; he's okay."

That forces us, of course, to take stock of the situation and ask ourselves why this paradoxical situation exists. How much of the criticism is justified, and how can we correct it? Why is it that the press seems to consider the letters AMA just a bit more genteel than four letter Anglo-Saxonisms - - -.

Whatever the reason, you can reliably depend upon it, if there is a slow news day - - - the boys in the editorial room will fire a blast at that good old standby the AMA.

Contrary to what you may have heard, the AMA is not the source of power in organized medicine. The County Medical Society is the source. A doctor cannot be a direct member of the AMA. He must be a member of his County Medical Society to be a member of the State Medical Association and he must be a member of the State Medical Association to be a member of the AMA.

Further, contrary to what you might think, a member of the Ohio State Medical Association is not required to be a member of the AMA. In addition, his not being a member does not compromise his ability to practice medicine. There are a few members of my own county society that do not belong to the AMA and I have no idea of who they are. So it obviously does not compromise their ability to practice.

I say this only to answer the often repeated

charge that we have the strongest union in the country.

Let me tell you something. You have never dealt with a wilder bunch of individualists who will not be intimidated than a group of doctors. If we just had half the union we are accused of having, and if our leaders had just one-tenth as much control over the individual doctors as you have been led to believe, then you can rest assured our wishes in the matters of the purveying of health care would long since have been listened to. But this is not what we want. We want members of the medical profession to have minds of their own, and we want them to speak their piece—and believe me they do when they feel they are being dictated to by their own leaders. We want membership in the AMA to remain voluntary.

217,000 Decide Voluntarily

Nationally, some 217,000 physicians have elected to join the AMA.

Delegates are elected from the county society to the state meetings where delegates are elected to the AMA House of Delegates. The House of Delegates elects the Board of Trustees and the President of the AMA. The Board of Trustees conducts the business of the organization between the semi-annual meetings of the House of Delegates. So you can see it is a grass roots organization. Now don't get me wrong; none of us here is naive. We all know that in any organization the opportunity often exists for grass roots participation, but it many times is not taken advantage of. We have our problems in this regard also, but we are working on getting more involved at the local levels in all matters, both political and medical.

But don't let anyone sell you on the idea that there are just a few iconoclasts sitting in headquarters in Chicago, who make all the decisions regarding medicine without regard to the membership's wishes. Naturally, I don't agree with all the decisions the leaders make, nor would I ever expect to, but the vocal few who charge they have no voice in policy, and who criticize the AMA bitterly from within the profession are a small minority, really.

The Real AMA

I dare say that there are few if any of you in this room who realize that the AMA does anything but spend astronomical sums of money in Washington in trying to thwart the will of the people by buying legislator's votes and in trying to elect candidates somewhat to the right of William McKinley in political philosophy.

Well, this "huge" AMA Washington lobby consists of less than a dozen persons covering 100 senators, 436 representatives, plus hundreds, if not thousands, of executive offices involved in medicine and health. I would be willing any time to have a comparison of all the energies and monies spent on lobbying activities with our friends of the AFL-CIO and their COPE organization. Anytime, that organization is welcome to "belly up to the bar" and put all of its cards, and we put ours, on the table. For over a hundred years the OSMA and AMA have had as their stated purposes the betterment of medical science and art and the protection of public health.

The AMA and the OSMA, as a component of the AMA, has had a direct involvement in:

The purity and quality of the drugs that you use;

The training and ethics of the physicians that treat you;

The safety and nutrition of the foods you eat;

The health and safety of your child in school and athletics;

The safety of your wife's cosmetics;

Exposure of medical quackery and chicanery;

The protection of the individual against unlicensed and incompetent practitioners

Also, through voluntary contributions from physicians, their wives and interested groups and concerns, there has been made available nearly $50 million in loans to medical students and outright donations of more than $40 million to the medical schools which have been given in the past 14 years. More than 1,000 meetings a year are held to help your doctor be a better doctor, or to promote public health and education.

These represent only an extremely small amount of AMA activity and on a smaller scale, the OSMA activities. If you were to visit the AMA headquarters in Chicago you would be amazed at the many committees, meeting daily from all over the country, dealing with the betterment of health for you, our patients—where the words "Medicare," Medicaid," or "Wilbur Cohen" are never even mentioned. But you don't hear of these, because they have become commonplace and, therefore, not news. I have given you this commercial message because it is vitally important to us that you, who we hope we can count among our friends, know a bit more about us than what you might read in the paper.

Times Have Changed

Not too many years ago it made little difference what political party was in power in Washington, from the standpoint of medicine. Whenever problems arose that were peculiar to medicine, either scientific or social, the people directly involved in providing medical care—US—

physicians—were usually consulted, as strange as that may seem. However, I am sure it comes as no great surprise to any of you that times have changed somewhat.

Now, because a problem is related to medicine does not mean that medical people will be consulted—*au contraire*—as recent history has demonstrated, we were not only not consulted, but our unsolicited advice was roundly ignored. Now this came as quite a shock to many doctors who thought that the only thing one needed to do politically was to think lovely thoughts and everything would come out peachy keen.

Thinking good thoughts was not enough. We found ourselves in the somewhat unpleasant position of coming in too late with too little, and found ourselves playing the game of our opponents, on their field, by their rules. We not only lost, but come out looking like heavies whose total commitment in life was to further the suffering of the poor and the aged in America—these same people who have been our friends and patients for lo these many years before and since.

We found ourselves in the unenviable position of knowing that the programs proposed, both Medicare and Medicaid, were going to be at least twice as expensive as the government witnesses said they were going to be, even if there were no inflation nor increase in the utilization of services. Other independent witnesses, such as insurance executives, etc., agreed to this, incidentally, and we also knew that when the programs did cost more than HEW estimated it would, HEW would then say that everything would have been all right if it hadn't been for those damn greedy doctors gouging the system. And, when Medicaid was added, the calculations were so bad that of the first year's estimate of the cost for 50 states, New York State alone would have taken about 80 percent or so of the total budgeted.

The government has been talking out of both sides of its mouth. Surely you will remember the high sounding mellifluous speeches about "no more charity medicine." Older Americans were assured that their medical care was now being taken care of, and they were encouraged to take advantage of it. It stands to reason, then, that the cost of care would go up since a great deal of work that was being done for free or for a reduced cost was now being billed at regular (not higher) rates. And this because of the solemn promise of the government, "That all your medical bills would be taken care of."

Medicaid the Sleeper

And then came along the sleeper Medicaid, or Title XIX as it is known. This, as you may know, is a part of the bill that takes care of the indigents under 65 and is administered by the states with federal direction and assistance. If you have been reading the papers at all lately, you have, I am sure, seen the juicy headlines about the names of doctors being published who have received $25,000 or more from Medicaid funds during the past year, and also you may have noticed that the Internal Revenue Service has obligingly agreed to give special attention to the auditing of the returns of these doctors. Well, let's take a look at that. For the fiscal year ending June 30, Ohio spent $101,883,000 under Medicaid. The number of cases was about 717,000, an increase of 116,000 over fiscal year ending 1968. Of the total expenditures for Medicaid, physicians received $7.7 million for their services. This represents about seven percent of the total health care expenditures under this program. Further, physicians are paid, when they are paid, only 60 percent of the fee they submit. It makes no difference if you lower your fees because the patient is on welfare, you then get paid 60 percent of your reduced fee. The 60 percent figure then equals the $7.7 million I was speaking of; full payment of the physician's usual and customary fee (not inflated fee) would have been $12,822,333, which means that Ohio physicians contributed $5,133,000 to the Ohio welfare patients this past year—that, in addition to many services rendered that weren't even billed because of the red tape involved, etc. I daresay that I would not be overwhelmed by a show of hands if I asked how many read that in the newspapers lately, would I? And, we really don't care about that.

Poor Are Not to Blame

Let me make it clear that we do not blame those unfortunates who are on relief, and we are pledged to see that they get care even if we do not get a dime for it, but we are a bit chagrined to have the welfare workers on the one hand encouraging these people to see their doctor anytime they wish and to tell them that the state will pick up the tab, and then have the state and federal government complain about the number of the welfare visits and accuse the doctors of overtreating.

Let me make another point abundantly clear. The Ohio State Medical Association has been and is still on public record many times in favor of a thorough investigation of the whole Title 19 and welfare system, and, when wrong doing is uncovered, we want those guilty punished. But we resent blanket charges and slurs that impune the whole profession without specifics to back up the allegations.

Publicity earlier this year about Ohio physicians paid $25,000 or more for services to Medicaid patients failed to point out that the few physicians it named happened to practice in or

near inter-city areas where a large number of their patients were on Medicaid and welfare. Further a check by the OSMA found that these payments averaged less than $50 per patient per year. Five or six visits a year could amount to that. Another omission from the news media stories was the fact that some of the services were provided and billed as far back as 1966—and some even before that—and were just now being paid. You didn't read about that, either.

Government Doesn't Know

When the president of the OSMA asked in the case of the physicians publicly named as having received $25,000 or more for the Ohio Department of Public Welfare to provide a breakdown of the number of patients seen, number of times each patient was seen, types of treatment, charge for professional services, etc., the Ohio Department of Public Welfare director of research and statistics wrote back, "The specific detail that you requested in items 6 through 11 of your letter cannot be provided. While some of the detail is now contained in state records, the cost of extracting it at this time is prohibitive. For some of the detail the cost of introducing it into the state records would be prohibitive."

In other words, the state seems to be saying that the cost of finding what welfare pays for and what it is getting for the taxpayers dollar is prohibitive.

The real tragedy about the publishing of these names and the harassment of these physicians is that most of them are working in the areas where the need is great and the monetary rewards often small. It seems grossly unfair to persecute men who are performing a sorely needed service to their patients and to their communities. If there are chiselers, let me assure you we don't want them any more than you do, but common decency should prohibit painting everyone with the same broad brush.

Well, I didn't come only to cry on your shoulders. I feel we should take a realistic look at our overall problems. Why are we in this mess to begin with? First, let me state that we know that all is not perfect with medical care in this country. There are deficiencies, and there are, I am sure, people not receiving the kind of care we would like for them to have. We firmly believe this should not be so.

Care Not to Be Denied

In a country as rich as ours, certainly no one should be denied medical care—the best available—nor should he be hungry in a land of plenty—nor should any one lack the necessities of life—nor hopefully a few luxuries too. The whole environment of the poor needs to be changed, this includes both the social and the educational aspects if we are going to solve the problems. The medical problem is but one of these, although it is a very important one.

The Question is not — do any problems exist, but — how big are they and how should they be solved? And the latter point is where it seems that the medical profession has run head-on into large segments of our population — that is, how should the problem be solved. The issue is an emotional one, and it does no good to point out that people already spend more on booze and cigarettes and TV repairmen than they do on doctors' services.

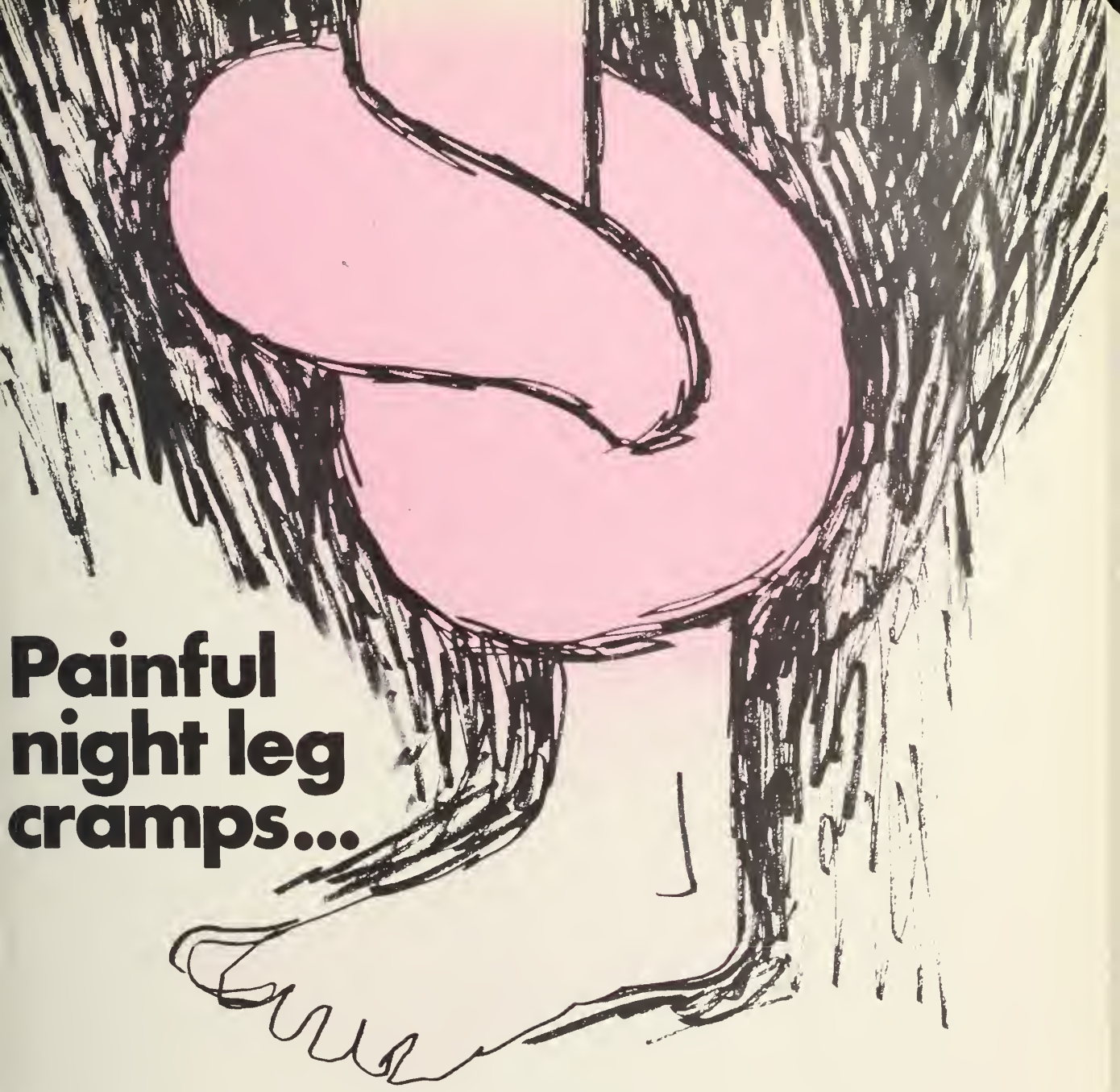
No one wants to be sick. It's like buying a dead horse. During the World Series a guy wants his TV fixed and is willing to pay for it through the teeth if need be, but in the first place, he certainly doesn't want his gallbladder out, let alone pay for it.

Social Planners Involved

So we have a philosophical hang-up with the social planners who frequent Washington in all administrations. Our problems are going to have to be solved by cooperative effort between the private and public sectors of our country. A very gifted and farseeing Frenchman named Alexis De Tocqueville saw this over a hundred years ago and reported it in his classic book *Democracy in America* — a remarkably current book considering it was written in the 1830's. He felt that this cooperation between the two sectors was one of the things that made this country unique and would enable it to climb to its position of prominence that it has. The problem now is that we now have a strong group of people in this country who wish to continually phase out the private sector. Our role is being relegated to smaller and smaller decisions.

Different Conclusions

I would like to make one thing clear now. Those who hold this different philosophy are not for the most part evil, conniving men, but are men who have taken the same set of problems that I have and have come to a different conclusion. Now this is all right, this is what makes a democracy tick. A man need not be your enemy to be your adversary in political matters. We need to remember this. This is what has been forgotten in recent months by those who would destroy our system. The mechanism for change is inherent in our political system. It is up to us to use the mechanism within the framework of the law. If



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

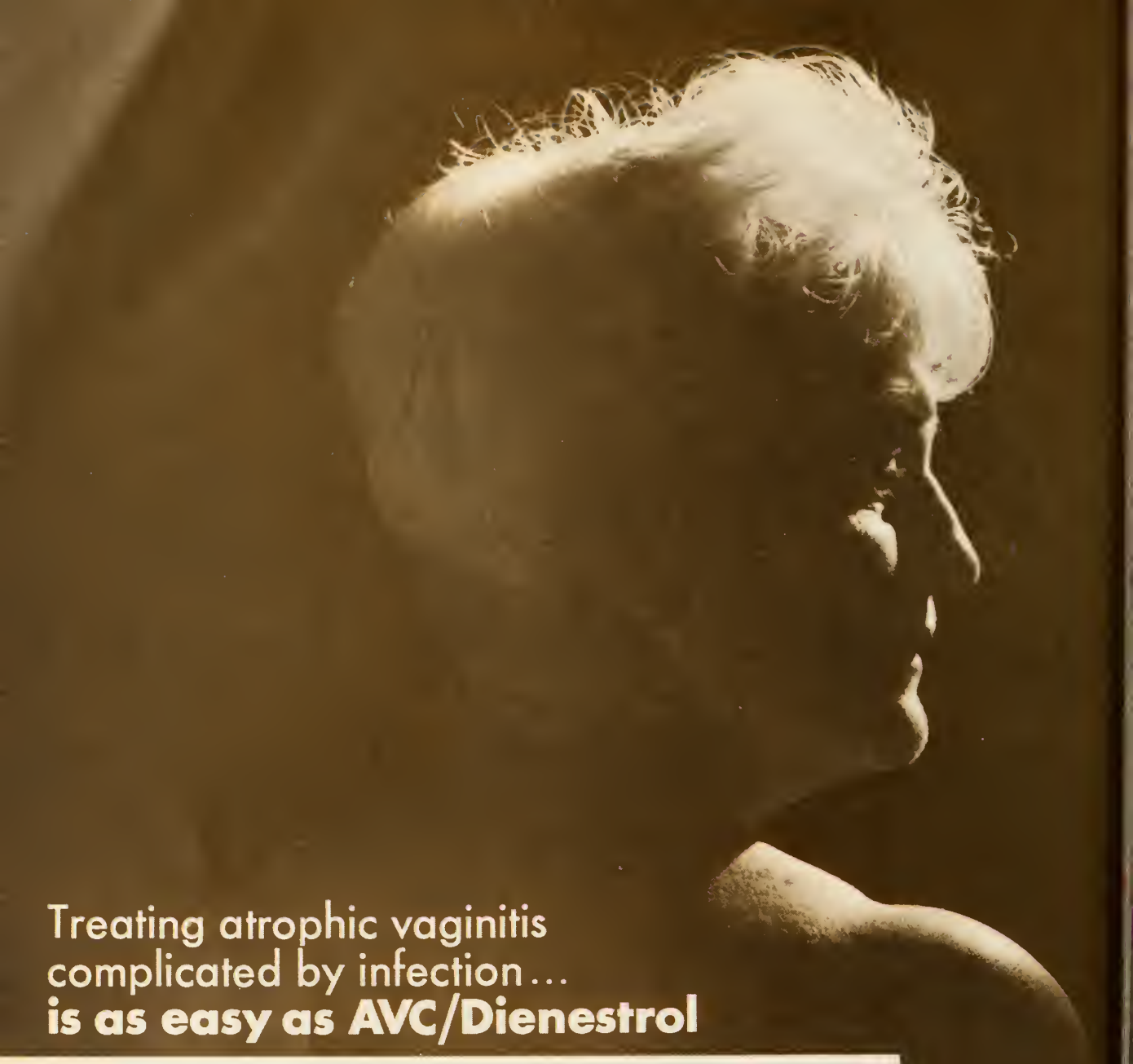
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Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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AVC/Dienestrol

Cream (dienestrol .01%, sulfonilamide 15.0%, ominacrine hydrochloride 0.2%, allantoin 2.0%)
Suppositories (dienestrol 0.70 mg., sulfonilamide 1.05 Gm., ominacrine hydrochloride 0.014 Gm., allantoin 0.14 Gm.)

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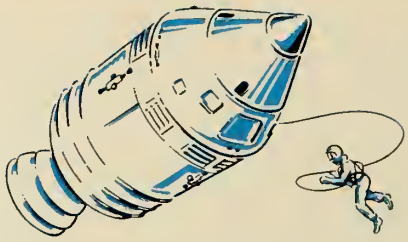
Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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we cannot convince the majority of our citizens that we are right, then we must abide by their decision until we can effect that change.

At any rate, there are those who feel strongly that the best and most efficient medical care is that which is totally administered by the government. There are those of us who disagree. In a democracy we have a right to express our opinion and to campaign for them using any honest means at our disposal. You are no doubt aware of the recent unpleasantness regarding the Dr. Knowles affair. I, of course, was not involved in the interworkings of that struggle, and know nothing of what actually went on. I can say this though, and I truly mean it when I say that I don't know what happened backstage in Washington or any where, but I am of the firm conviction that if the medical profession felt that it could not cooperatively work with Dr. Knowles, it had a perfect right to say so. I do not find the fact unusual that it might make sense to have some rapport between an appointed official and the group of professionals with whom he has to work. I will not go into any reasons or personalities this time, but will say that if he had been appointed, organized medicine would have done its best to work with him, and would not have screamed foul to the press. In leaving that subject I would just say that if Mr. Humphrey had won the election and had appointed Barry Goldwater as his Secretary of Labor, I wonder if the press would feel such editorial anguish if Mr. George Meany found it within himself perhaps to mildly protest the appointment.

Why Fear Controls?

A legitimate question I think may be, Why do we fear governmental control over the practice of medicine? Is it just monetary? Well, I am reasonably sure you don't expect me to answer that question with a "yes" and I won't disappoint you. One cannot dismiss that consideration completely, however, and I think a fair answer should be given. Nobody knows for sure, of course, but I would expect the income of doctors to increase at first, or at least stay the same, but over the long haul it would likely decline, but that is really not the main problem — believe it or not. The main issue is the delivery of medical care of the highest possible quality, and in the best manner possible. We believe this is best done with a personal doctor-patient relationship in a system that allows the doctor the individual freedom to prescribe what he feels best for a particular individual.

Source of Difference

Here is where one of the biggest hang-ups occur. Government planners tend to look upon the practice of medicine as a pure science. It definitely is not. It is both an art and a science. Everyone is an individual including each of you and no one on God's green earth can sit in Washington or Columbus, nor anywhere else except across from that particular patient and decide what is best for that person. It can't be done.

There is another area where the government plans go off the deep end — it's showy but not effective — when they want a particular problem studied they pick a dazzling array of big names — men who are experts in some fields of medicine — but who really know absolutely nothing about the private practice of medicine or about what's going on each day out on the firing line.

Because a doctor may be a world renowned professor of medicine or surgery at a medical school does not mean that he is an expert on the private practice of medicine out in the boondocks. Indeed, it is likely that he has never been in a private office in his life except as a patient, perhaps. Now this does not mean that his counsel should not be sought, but to constitute the whole committee of such men doesn't make sense.

I have talked a lot about problems — what about solutions and alternatives.

Political Action Is Key

I'll tell you what we are doing in one area. It has taken us a woefully long time, but we, in medicine, are finally learning that there is nothing sinful, wrong, or underhanded about an individual or organization becoming involved in the business of running his country. Indeed, it is not only not wrong, but it is inexcusable to avoid this responsibility. Justice Oliver Wendell Holmes once said, "It is required of a man that he should share the action and passion of his times at peril of being judged not to have lived." I like that. It says: Get involved. That is why I am here tonight. I am involved, and I want to get you involved. We found out sometime ago that the place to influence legislation was in November of an election year — not in Washington in January. It is imperative that we all become involved in the active support of good men who are willing to run for political office. He doesn't have to see eye-to-eye with you on all issues, and you certainly don't want a man you can buy, but hopefully you will want a man who shares your same general philosophy, and who will be progressive — not ignoring the present pressing problems that face us today — but be willing to try other solutions than joining the already overcrowded chorus of those who wish to abdicate their responsibilities to the great eter-

nal fountain of wealth from whence all blessings flow on the banks of the Potomac.

Apathy Is Dangerous

One of the biggest problems facing us today is political apathy. Each of you should have taken the time to develop a political philosophy and be willing to support candidates with whom you can identify — with both your time and money. You cannot enjoy the luxury of being neutral. This is not the time in America for political eunuchs. So one alternative is to try to work within our present political set up to elect men of high calibre with whom we can communicate and discuss our problems.

I hope that your organization has a political action committee or group but, if you do not, we have one in which you are more than welcome. OMPAC — The Ohio Medical Political Action Committee — has been very active for the past several years in these same areas to which I am now alluding. We would welcome any and all of your memberships. It costs but $25 a year to join and I can assure you that it will be a wise investment of your money. I will be happy to provide you with specific information as to how to join if you so desire.

The other alternative to me is rather grim. We can follow the lead of Great Britain and other European countries.

Last year I had the privilege of visiting with a British doctor in his home and his office. We were both mutually curious about a great many details of our various practices.

Trivia Is Overwhelming

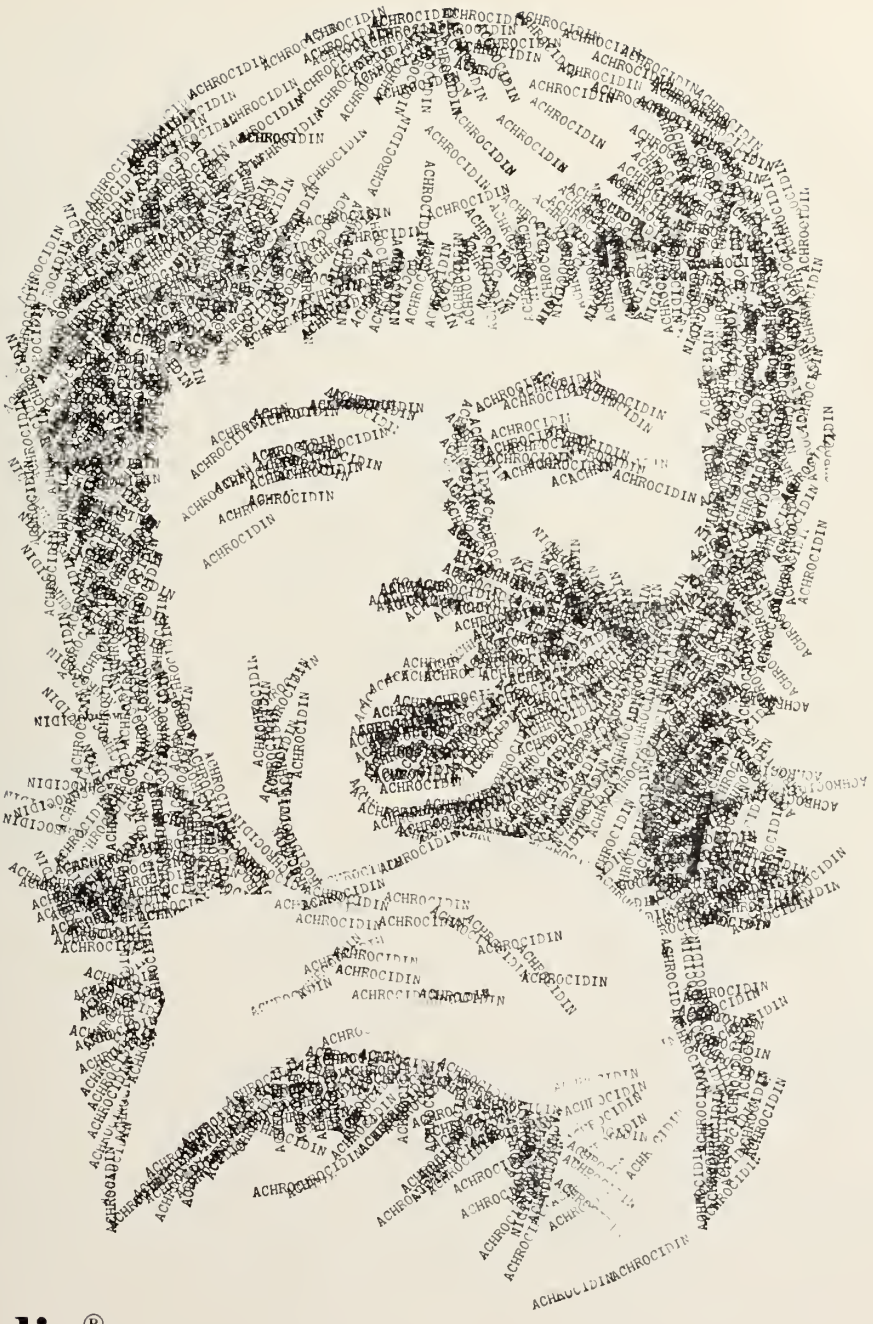
When I asked him how things were going, he said: "Doctor, we are overwhelmed with trivia." He did say, however, that he and his associates made about 20 to 30 house calls a day, which presumably makes British editorial writers happy although it is a tragic waste of medical manpower. (Please don't misunderstand me. House calls are often necessary, and my partner and I do make them.) There had been some recent turmoil in the system in Great Britain relative to the lot of the general practitioners before I had arrived there and it had been resolved with some improvement in the lot of the G.P., but Dr. Jones told me that before that had occurred he was getting ready to emigrate. Think of that! Here was a man 52 years old thinking of pulling up stakes and starting all over again in a new country—Canada or Australia perhaps. That, my friends, is a drastic step.

He was also concerned about the loss of their bright young men who either did not go into medicine or, if they did, tried to come to America at the first possible opportunity. Here was a man who was not bitter — was not out carrying signs to repeal the system. He found some good in it, but he was very concerned about the quality of medical care that was being delivered. He said, and again I quote: "We are being reduced to mediocracy." I asked him what bit of advice he would give to me to bring back since I told him that we were doing our best over here to out-British the British. He said: "For God's sake, don't make everything free; don't relieve the patient completely of the responsibility for his own welfare if he can possibly afford it — even if it is a small amount." And then he said something very significant. He said that, as you perhaps know, the late Lord Beveridge was responsible for drafting the social welfare plan now existant in Great Britain. He said that Lord Beveridge drew up a beautiful plan on paper. He showed beyond a shadow of a doubt that the absenteeism from work was high because of inadequate health care of the people, and that if "free" medical care were available, and I use the word free in quotes, the same people would have access to better care and therefore they would miss less work — the gross national product would rise — and the health service would not only pay for itself, but would make a profit. It was a thing of beauty, Dr. Jones said, and a joy to behold. But alas, Lord Beveridge took into account every factor but one — PEOPLE. And therein lies the rub.

Heirs to A Heritage

Ladies and gentlemen, all of us in this room tonight are the heirs to a great heritage of freedom and liberty. We are also heirs to a tradition of concern for those who are less fortunate than we, and for those whose lives have not been as pleasant as ours, only because they are black or yellow or speak with an accent, or go to the wrong church. History will judge us as it has all man and all generations. It will note what we have received from the past, and will pass judgment on our stewardship when it is time for a new generation and a new age to assume command.

Perhaps we cannot change the course of history. Perhaps, as the cynics say, we can do nothing but ride the tide of socialism to its better end. I do not have the final answer. But, when that judgment is written, let it be said that we tried at least to support intelligent, progressive solutions to our country's problems, solutions that would provide alternatives to the completely paternalistic state. And let it further be said that here were men at least who were determined that the cause of freedom was not going to lose by default, nor for the want of a champion.



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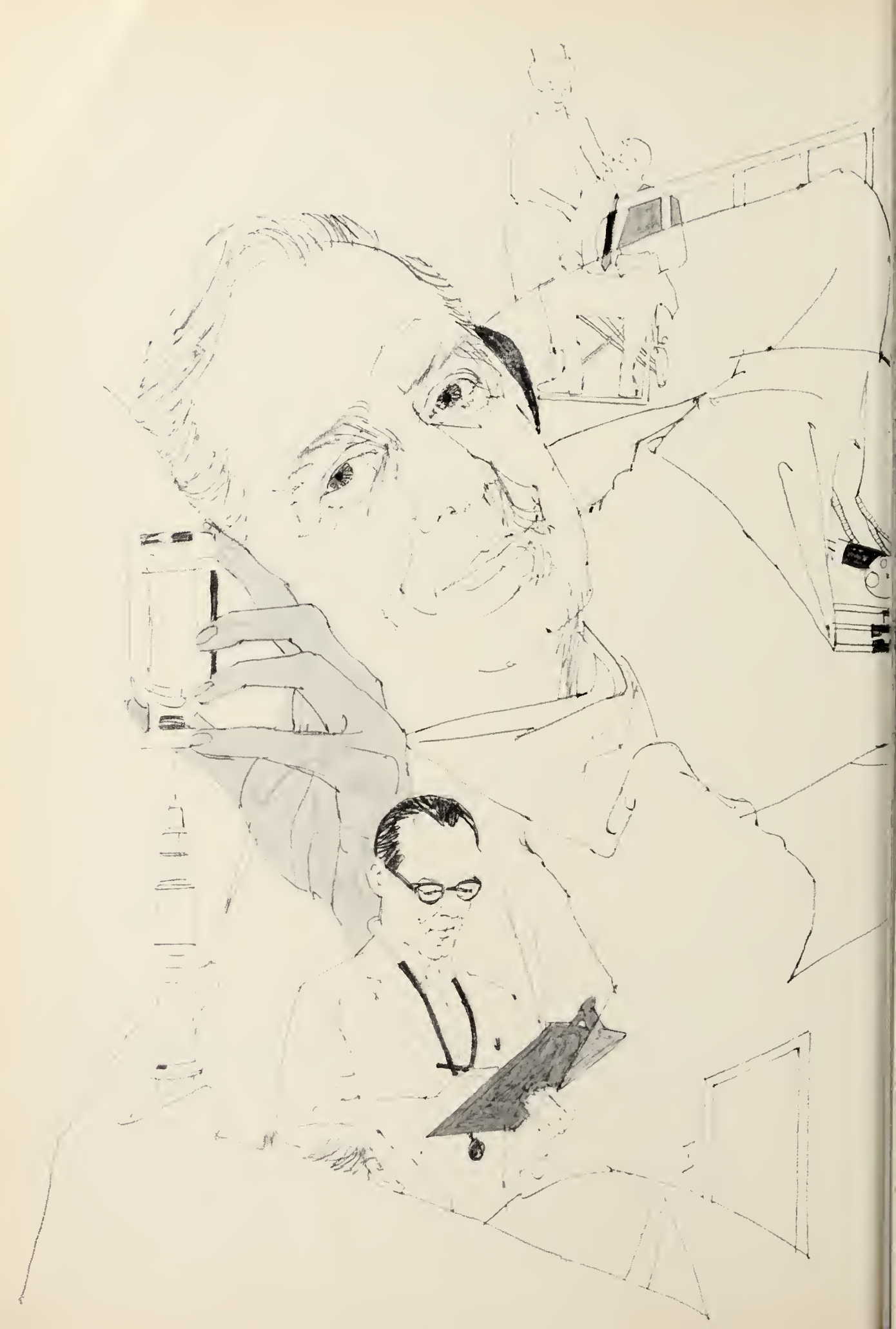
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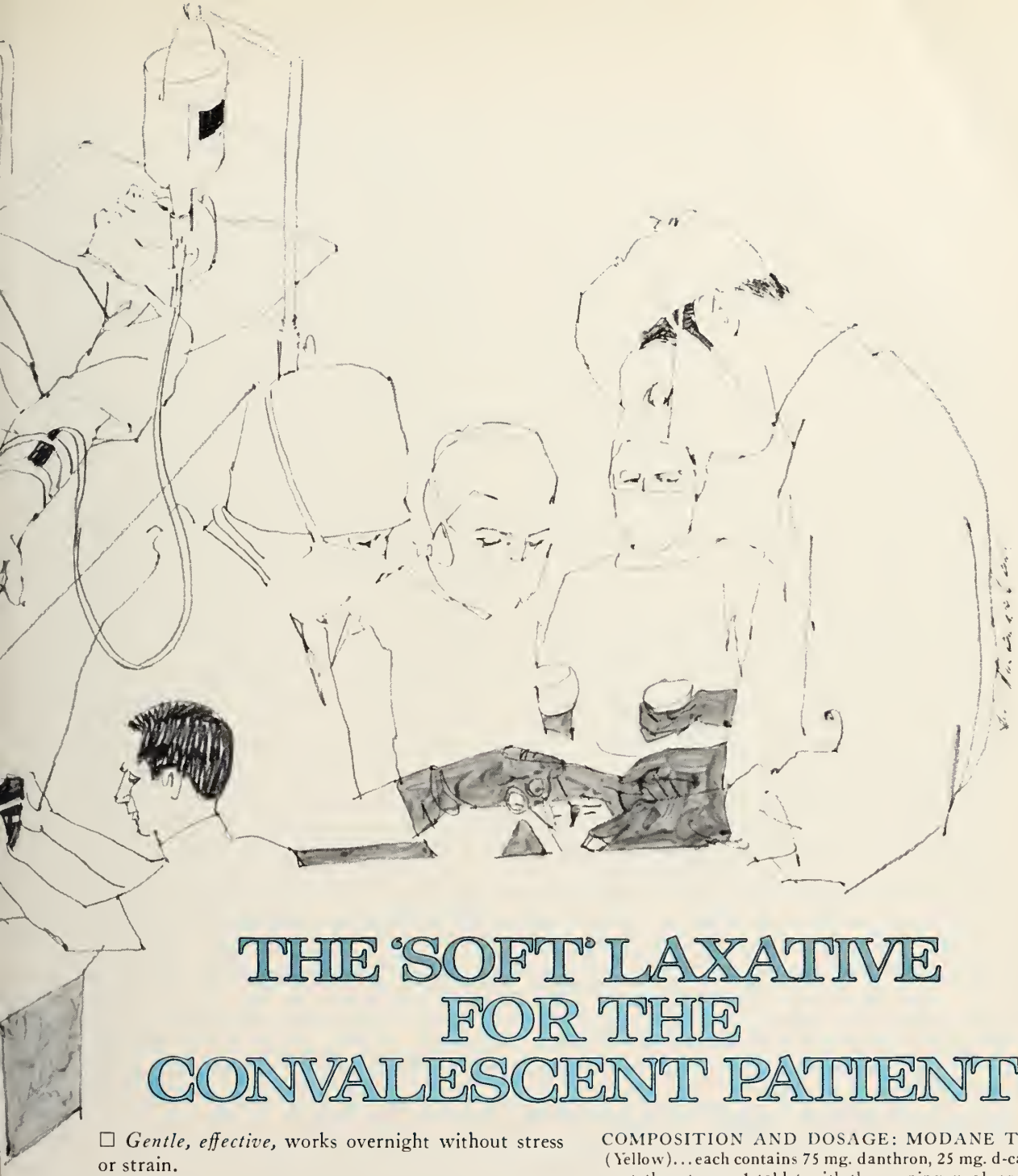
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Medical Students at Toledo Get Early Exposure to Practice in Doctors' Offices

Less than three months into their studies, the entire student body of the Medical College of Ohio at Toledo left their classrooms and laboratories on Wednesday, December 3, to join practicing physicians across a six-county area of Northwestern Ohio for an insight into the actual practice of medicine.

Twenty-nine doctors, with offices from Huron to Bryan, cooperated in the MCOT project. They gave the students first hand knowledge of how a physician helps and heals his patients in the traditional setting of the nonmetropolitan community.

Dr. Howard S. Madigan, assistant dean at MCOT, initiated the program as part of the curriculum in human ecology.

"By placing the students in the office of general practitioners and specialists at this early stage of their college work, we hope they will gain an insight into this type of practice," Dr. Madigan said. "We believe it will show them the vast opportunities which exist here for serving the public."

The charter class of 32 students entered the Medical College of Ohio last September. (See November issue of *The Journal* for a report of the opening.)

The host physicians invited the students, essentially as observers, Dr. Madigan said. However, in many instances there were opportunities for the students to talk with patients and their families—not in terms of diagnosis or treatment—but as an early experience with the doctor-patient relationship and communication.

"Our primary objective is to have the student discover the essential need for communicating with his patients," Dr. Madigan said.

Following are the names of physicians who volunteered to participate in the unique program:

Archbold—Drs. R. A. Ebersole, E. R. Murbach, and D. A. Stotzer.

Bryan—Drs. D. F. Cameron, N. T. Levenson, H. B. Mayberry, and A. G. Jackson.

Defiance—Drs. L. Berry, W. Busteed, R. Cunningham, P. Palmer, H. W. Reas, and B. Sickmiller.

Fayette—Dr. R. W. Nyce.

Fremont—Drs. E. Dierkscheide and D. H. Smith.

Huron—Drs. R. D. Gillette and R. H. Williamson.

Napoleon—Drs. T. F. Moriarty and W. J. Stough.

Sandusky—Drs. H. L. Hoffman, F. Lavendar, W. Parker, and D. Richenbach.

Wauseon—Drs. R. F. Bruns, R. L. Davis, and F. E. Elliott.

Dr. Albert C. Esposito, Huntington, W. Va., was named president-elect of the Southern Medical Association at the organizations annual meeting in Atlanta, Ga. A specialist in ophthalmology, Dr. Esposito took much of his residency training at Ohio State University College of Medicine in Columbus.



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Chairman Elected for Joint Advisory Committee on Athletic Injuries

Sol Maggied, M.D., of West Jefferson, recently was elected chairman of the Joint Advisory Committee on Athletic Injuries of the Ohio State Medical Association and Ohio High School Athletic Association.

Dr. Maggied succeeds Paul E. Landis, of Worthington, who had served as chairman since 1966. Mr. Landis recently retired as commissioner of the Ohio High School Athletic Association.

The committee was formed by the two organizations in 1960 to establish all possible safeguards for the health and safety of high school athletes. Among its numerous activities have been development of a standardized physical examination form, an annual campaign to prevent heat exhaustion and heat stroke among football players, and annual postgraduate conferences on athletic injuries for Ohio physicians, coaches, trainers and educators.

Dr. Maggied is a graduate of Columbus East High School. In his senior year, he was named to the All-Ohio high school football team. He took his premedical and medical training at The Ohio State University and, while an undergraduate, played on the OSU varsity football team.

Dr. Maggied has been in the family practice of Medicine in West Jefferson for 23 years. He has served as a team physician during that period and has also served as a basketball and football official. He has been a member of the Joint Advisory Committee on Athletic Injuries of the OSMA and OHSAA since its inception in 1960.

For the past 15 years, Dr. Maggied has served as the Madison County Medical Society delegate to the OSMA House of Delegates.

Paul Landis Honored at Testimonial Dinner

Paul Landis, retiring Commissioner of the Ohio High School Athletic Association, was honored recently at a testimonial dinner attended by three out-of-state dignitaries and some 200 friends and co-workers. The evening's festivities were at the Ohio Union on the campus of Ohio State University in Columbus.

Mr. Landis, long associated with the Ohio High School Athletic Association, was Commissioner from 1966 to 1969. Among key persons present were Clifford Fagan, executive secretary of the National Federation of State High School Athletic Associations; Allen Bush, state director of the Michigan Athletic Association, and Gordon Eismon, executive secretary of the West Virginia High School Activities Association.

The new OHSAA Commissioner Harold Meyer served as master of ceremonies. Dr. Sol Maggied, chairman of the Joint Advisory Committee on Athletic Injuries; and Dr. Thomas Schaefer, Columbus, chairman of the Committee on Medical Aspects of Sports of the AMA, were among persons who spoke.

On behalf of OSMA, Dr. Maggied presented a plaque to Mr. Landis containing a resolution introduced by Dr. Maggied and passed by the OSMA House of Delegates at the 1969 Annual Meeting. The resolution commended Mr. Landis for his numerous contributions to the health and safety of thousands of Ohio scholastic athletes.

New Regulations Relating to Cough Syrups Containing Paregoric and Codeine

Following is the text of a statement issued October 14, 1969 by Frank E. Kunkel, Executive Secretary of the Ohio State Board of Pharmacy.

"New U.S. Department of Justice, Bureau of Narcotics and Dangerous Drugs regulations controlling the distribution of paregoric and codeine containing cough syrups become effective October 15, 1969.

"Revised conditions for sale of these products require the purchaser to provide suitable identification and proof of age to the pharmacist who must personally make the sale. No one under 18 years of age may purchase these exempt narcotic products without a prescription.

"Ohio narcotic laws are more restrictive than the federal and limit purchases to one ounce of paregoric or not more than four ounces of any other exempt narcotic containing product in any given 48 hour period.

"The Bureau, Pharmacy Board and local law enforcement agencies will step up inspection and investigative procedures to insure immediate compliance with the new regulations. This attempt to remedy the growing abuse of paregoric and codeine cough syrups will be monitored carefully and, if not successful, the Bureau of Narcotics and Dangerous Drugs will consider lifting the exemption and requiring sales of these products on a prescription only basis."

As pointed out in the text, these regulations are directed to the pharmacist. They would not limit the physician who dispenses these items as part of his professional services to the patient.

and we "Quote"

Of the Writing of Journals, There Is No End

"We are in the midst of a crisis of scientific communication. Let us look at the number of scientific journals published in the last hundred years or so; in 1850 there were 1000, in 1900 there were 5000 and in 1967 no less than 27,000 scientific journals. It is obvious that medical communication is suffering from severe oedema.

"The trend towards more and more specialization has led to a proliferation of specialist journals and to professional isolation; it has also put an ever-increasing distance between the doctor and the human beings who are his patients. For a practitioner of clinical medicine who wants to examine and cure the human being as a whole, it becomes increasingly difficult to know where to turn for fresh information."—Annals of Clinical Research.

The I-Can-Do-It-Alone Physician Is a Man Without Representation

"Of all the trends in Medicare, this latter trend (toward central control) has the greatest impact on the individual practicing physician. It is apparent that the man without an organization to represent him, is a man without representation. With the advent of Medicare, the medical societies, either the existing ones or ones to be evolved, were placed in the position in which they could become the physicians' most important representatives at the bargaining table."—John A. Buesseler, M.D., in The Journal of the Kansas Medical Society.

Or, What Will We Take in Exchange?

"In the AMA and its collaborating associations, we have a real good thing. But can we keep it?"—Journal of the Medical Association of the State of Alabama.

Nonmedical Friends in the Community Driver's Seat

"We all owe our community something besides the right and privilege of serving the medical needs of the people. Of course, you are busy. You need what little spare time you have for your families and for rest and recreation. *Somehow,* we must find time to help our communities in a nonmedical way. We *must not* let our nonmedical friends provide *all* the leadership in community affairs. Infiltrate!"—Doyle C. McGraw, M.D., President-Elect, Missouri State Medical Association.

Oh, My Achin' Back!

There's an old saying that if you have a piano to move, you can get volunteers to carry the piano stool.

Stimulating the Overdrive in Mental Processes

Reflection on these ideas and questions led the Executive Committee on Medical Education to decide against a five-day conference of lectures, a type of program in which the participants are talked to, but are given no chance to respond. For most people, speaking in public or thinking aloud somehow stimulates an overdrive in the mental processes which is not activated when they are passive listeners.—Introduction to Third World Conference on Medical Education.

Medical Students and Practitioners — A Communications Gap

"There is further and encouraging evidence that medical students today are becoming more interested in the personal care of patients. I am not referring to the small minority of students who gain the headlines with their desire to destroy organized medicine and the system of medical practice as we know it—but have nothing constructive to offer in its place. I refer to the sincere, intelligent young men and women whose views are reflected in a statement made to me recently by a senior student at a large mid-western medical school. He said 'I intend to practice medicine for a living when I get out. Yet, in three years of medical school, I have had no exposure to the private practice of medicine, nor have I even

met a physician in private practice—except on my own initiative in my home town during vacation.' "—Henry B. Asman, M.D., in The Journal of the Kentucky Medical Association.

Heterogeneous Communications Between Professions Urged

"- - - Professions very often are guilty of intellectual inbreeding. Doctors write for medical journals, lawyers write for legal journals, educators write for educational journals. This enhances knowledge within each profession, but there must be more communication among professions. - - -"—Paul A. Miller, Superintendent, Cincinnati Public Schools, in the Cincinnati Journal of Medicine.

You Can't 'Bury' Family Practice and Administer It too, Doctor Vows

"Recently one of the present graduates of the University of Utah visited with me. His expressed desire was to see what general practice is really like.

"He told me at the beginning of his medical school training, 15 individuals were interested in general practice. During the school years the family doctor was painted as being a thing of the past, (soon to be non-existent). Of the 15 who started out to be general practitioners (family doctors), only three remain leaning toward this type practice. (These three are very skeptical of it now.) - - -

"The only way to get more family doctors is to paint a brighter picture for this type practice and to orient the medical students toward this type of practice instead of tearing it down and burying it.

"When 15 people change their minds about general practice in the process of education, something needs to be done to keep people of this type thinking along the same line. - - -

"The only way people in outlying counties will get good medical care is to send them well-trained medical personnel, ones that are determined that this is their way of life. - - -

"I am convinced that if there were a more positive family practice program in medical school, then there would be more students interested in family practice following graduation. - - -"—Paul G. Stringham, M.D., in the Utah Medical Bulletin.

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16	3.50	4.40
25	4.52	4.47

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Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum.
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Clinical & Scientific Features




VOLUME 66 JANUARY, 1970 NUMBER 1

Early Discharge Following Inguinal Herniorrhaphy

JACK E. TETIRICK, M.D.

IN 1938, Gertrude Herzfeld reviewed her experience with 1,000 cases of indirect inguinal herniorrhaphy in infants and recommended discharge on the day of surgery.[1] Othersen and Clatworthy confirmed this recommendation after a ten year trial reported in 1968.[2] Other surveys of early discharge following inguinal herniorrhaphy in patients of all ages routinely report no evidence of harm to the patient.[3–5] Despite these reports, the average length of hospital convalescence following inguinal herniorrhaphy in adult patients was 6.1 days for 199 patients and 6.9 days for 393 patients in two large community hospitals recently surveyed. I have, therefore, examined the records of all patients undergoing inguinal herniorrhaphy on my service during the preceding 12 years to determine the duration of postoperative hospital convalescence and the reasons governing the time of discharge.

Three hundred and forty-five operations were performed on 337 patients. Seventy-six patients were children (4 weeks to 16 years of age) and 269 patients were adults (16 years to 91 years). The average postoperative stay for children was 1.7 days and for adults was 5.6 days. Table 1 shows the incidence of postoperative deaths, complications, and recurrence. Tables 2 and 3 show the distribution of cases according to the variety of inguinal hernia and the corresponding distribution of the length of postoperative stay. Delay in discharge is not related significantly to the type of hernia.

The Author

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Postoperative Stay

The length of postoperative stay is related to the age of the patient as shown in Figure 1. Despite this fact, the number of adults discharged on or before the 4th postoperative day is constant at 40 to 45 percent until the seventh decade as shown in Table 4. When the adult patients are regrouped according to the number of postoperative days spent in convalescence, the bar graph shown in Figure 2 is produced in which the number of patients with a postoperative hospital stay

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Submitted August 28, 1969.

of seven days contrasts sharply from what otherwise appears to be a reasonable distribution curve.

The records were then studied for the reasons why children remained beyond the second postoperative day and adults remained beyond the fourth postoperative day. The reasons were subdivided into physician reasons (surgeons, medical or pediatric consultants, referring physician); patient or family reasons; and reasons of bona fide medical treatment. The results are shown in Tables 5 and 6. The delay in discharge of children is confined to a small percentage of patients and an insignificant total number of days. The adults, however, overstay in greater numbers. However, only 23 of 269 adults remained for reasons of bona fide medical treatment. The delay by the physicians and by the patient or family for reasons other than medical treatment accounted for over 71 percent of the total delay in discharge beyond the fourth postoperative day.

A list of the 23 patients regarded as having complications is presented in Table 7. There was one infection in the entire series. Much of the medical delay was anticipated before surgery or

Table 1. Mortality, Morbidity, and Recurrence in Inguinal Herniorrhaphy 1957-1968

	345 Cases	
76 Children (4 wks. to 15 yrs.)		269 Adults (16 yrs. to 91 yrs.)
Deaths	2	.58%
Complications	23	6.70%
Recurrences	9	2.70%

Table 2. Distribution of Cases According to Type of Hernia

Children			Adults	
Unilateral	Bilateral		Unilateral	Bilateral
4		Direct	51	17
60*	12	Indirect	169	21
		Sliding	9	2
3		Recurrent	26	
5		Incarcerated	5	

*11 opposite side explored with negative results

Table 3. Average Days of Postoperative Stay Related to Types of Hernia

All Patients			76 Children 1.7 Days 269 Adults 5.6 Days	
Unilateral	Bilateral		Unilateral	Bilateral
2		Direct	5.8	5.5
1.8	1.3	Indirect	5.3	5.8
		Sliding	6.7	9
3		Recurrent	6.3	
2		Incarcerated	8.8	

Table 4. Discharged on or before Fourth Postoperative Day

16-19	44%
20-29	45%
30-39	45%
40-49	40%
50-59	43%
60-69	26%
70-79	16%

Table 5. Delay of Discharge
13 of 76 Children Beyond Second Postoperative Day

Reason	Patients	Total Days
Physician	5	6
Patient or Family	7	8
Medical Treatment	1	1

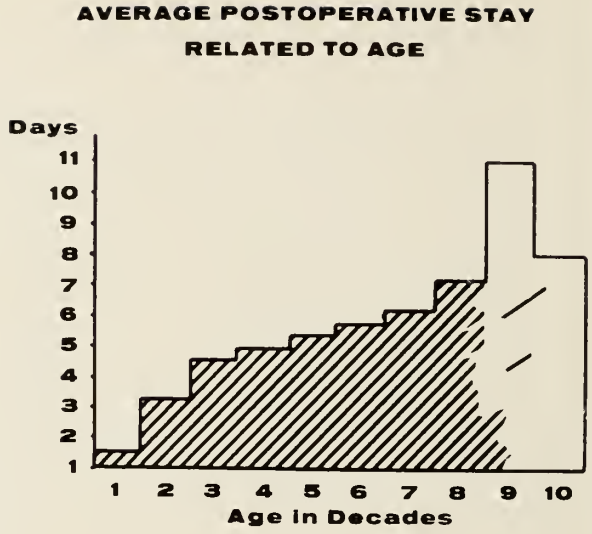


Fig. 1. The average length of postoperative hospital stay increases with each decade. (The small number of patients in the last two decades renders data insignificant.)

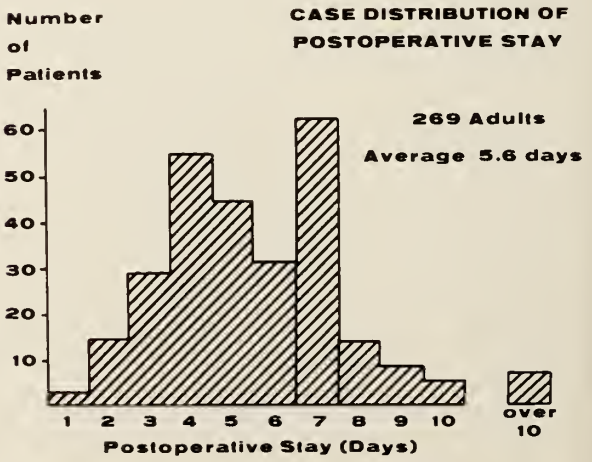


Fig. 2. The number of adult patients discharged on each postoperative day is shown in the bar graph. The seventh postoperative day stands out as "ritual day" for the removal of sutures.

Table 6. Delay of Discharge
170 of 269 Adults Beyond Fourth Postoperative Day

Reason	Patients	Total Days	Avg.
Physician	45	121	2.7
Patient or Family	102	224	2.2
Medical Treatment	23	140	6.0

Table 7. Delay of Discharge for Medical Treatment

Reason	Postoperative Convalescence (Days)	Age (Years)
Wound infection	9	16
Pulmonary cripple, bronchiectasis	8	35
Constipation	8	47
Urinary tract infection	7	53
Prostatic obstruction	10	54
Pneumonitis	9	55
Scrotal hematoma	16	55
Diabetes, urinary tract infection	10	55
Pulmonary emphysema and fibrosis	7	58
Fever of unknown etiology	8	59
Regulation anticoagulant therapy	13	62
Laparotomy for carcinoma of stomach	12	62
Bronchitis	6	64
Recovery from small bowel resection	9	65
Regulation of diabetes	14	66
Regulation hypertensive cardiovascular disease	8	66
Congestive heart failure	7	66
Prostatic obstruction	7	68
Congestive heart failure*	13	71
Pulmonary insufficiency	10	73
Scrotal hematoma	15	73
Recovery from bowel resection	9	73
Myocardial infarction and CVA*	17	81

*Postoperative death

Table 8. Mortality and Morbidity Statistics Related to Age of Patient

Mortality	0.58%	Complications	6.7%
Children	0.00%		0.0%
Adults	0.74%		8.5%
16-49	0.00%		2.3%
50-69	0.00%		14.8%
70-91	8.70%		21.8%

at the time of surgery, such as the regulation and resumption of anticoagulant therapy or recovery from the resection of a gangrenous segment of bowel. What is most important, however, is that review of all charts revealed quite clearly that a complicated convalescence could be predicted with confidence by the morning of the third postoperative day either by inspection of the chart, knowledge of the patient's history or operative findings, listening to the complaints of the patient, or by inspection of the operative incision. All other patients with a normal convalescence at this time (third postoperative day) could have been discharged.

Table 8 restates the mortality and morbidity encountered in the series by relating these occurrences to the age of the patient. As such it is another testimony to the desirability of performing elective herniorrhaphy before incarceration and the degenerative process of aging appear.

Advantages of Early Discharge

The study of these cases confirms the opinion of others that early discharge following inguinal herniorrhaphy should be usual and standard practice. This has been accomplished in the pediatric patient in community hospitals but is lacking in the instance of adult patients. Physician delay is one of precaution, observation, overdiagnosis, and ritual (i.e. hospital removal of sutures on 7th day). Patient and family delay is due to a combination of folklore, misinformation, inertia, and fear. The patient who is informed before elective surgery that his postoperative hospital stay will be two or three days is rarely a problem, the patient who expects to stay a week and is discharged in 72 hours sometimes feels cheated.

For a surgeon to discharge a patient with a healing incision requires great confidence in aseptic technic in the operating room, in vigorous and alert postoperative care, and the cooperation of the family physician. Such support is easily within the grasp of modern community hospitals. Early discharge following inguinal herniorrhaphy would seem to represent a worthwhile conservation of health resources obtainable without harm or discomfort to the patient.

Summary

For a review of the records of 345 cases of inguinal herniorrhaphy performed by one surgeon, only 23 adult patients needed to remain hospitalized beyond the morning of the third postoperative day for reasons of medical treatment. The bulk of the total delay in discharge was in adult patients and for reasons other than medical treatment.

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Gross Examination of Curettings In Endometrial Carcinoma

Alyson L. Palmer, M.D., and Erlo Roth, M.D.

IT IS common practice to perform a uterine curettage as a combined procedure immediately prior to hysterectomy for benign disease. The purpose is to rule out the presence of carcinoma of the endometrium, which requires management other than an immediate simple hysterectomy.[1] Some physicians rely on the gross appearance of the curettings in deciding whether or not to proceed with the hysterectomy planned. The present study was undertaken to determine the accuracy of this judgment.

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Materials and Methods

The hospital records of all patients with a diagnosis of endometrial carcinoma in the files of C. F. Kettering Memorial Hospital were reviewed. The pathologic findings were correlated with the clinical impressions and the description of the curettings at the time of operation. Follow-up information was obtained from the Tumor Registry on those patients not receiving definitive treatment at this institution. Thirty-four patients with invasive adenocarcinoma of the endometrium were found. Twenty-eight of these had a curettage and these were selected for the study.

Results

The data are summarized in Table 1. Of 28 patients with endometrial carcinoma, in only two were the curettings correctly interpreted as suspicious of malignant tumor on the basis of gross appearance alone, and hysterectomy was postponed until after irradiation. In an additional nine patients, the curettings were either described as suspicious or were assumed to be so regarded because a frozen section examination had been requested. In these, endometrial carcinoma had been suspected on clinical grounds prior to curettage; therefore, the request for frozen sections may not have been based entirely on the appearance of the curetted tissue. Only two of these patients had a hysterectomy without prior irradiation. The presence of endometrial carcinoma was entirely unsuspected in 17 patients, even after curettage. In one of these, a frozen section was requested because an abnormality other than carcinoma was surmised, and hysterectomy was not being contemplated. On the basis of gross examination of curettings, therefore, carcinoma was unsuspected in 17 patients (60.7 percent). Gynecologists overlooked carcinoma less frequently (7/13 or 54 percent) than surgeons and general practitioners (10/15 or 67 percent). The difference is not statistically significant.

On clinical grounds alone, carcinoma was unsuspected in 19 of 28 patients (67.8 percent). If the six patients undergoing hysterectomy without prior curettage are included, the precentage of carcinomas undiagnosed until after histologic examination is 75.9 percent.

Discussion

Simple hysterectomy alone is not considered to be adequate treatment for invasive carcinoma of the endometrium.[2] Either a radical hysterectomy or irradiation followed by simple hysterectomy is advocated, the latter method being preferred particularly because it leads to fewer vaginal metastases.[3]

When a hysterectomy is planned for benign

Submitted October 10, 1969.

Table 1. Endometrial Curettings with Adenocarcinoma

	Patients	%	Frozen Section	Hysterectomy Without Radiation
Cancer suspected from gross appearance only	2	6.9	0	0
Cancer suspected partly on clinical grounds	9	34.5	5	2
Cancer not suspected	17	58.6	1	13
Total	**28**	**100.0**	6	**15**

disease, it should be preceded with a curettage in order to search for carcinoma of the endometrium so that, if present, the patient may be given the appropriate therapy. The frequency with which endometrial carcinoma was unexpected on clinical grounds, (75.9 percent) justifies this procedure. Inasmuch as our data indicate that mere visual inspection of the curettings fails in most instances to alert the physician to the presence of cancer, a frozen section examination should be performed on all such curettings.

Summary

Gross examination alone of the curettings of 28 patients with endometrial carcinoma failed to alert the physician to the presence of malignant tumor in at least 17 patients (60.7 percent). This resulted in 13 simple hysterectomies without the benefit of preceding irradiation. It is recommended that all curettings obtained prior to hysterectomy for benign disease be examined by frozen section.

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AFTER INGUINAL HERNIORRHAPHY under local anesthesia, the patient usually is discharged from the hospital the same day and permitted immediate return to unrestricted work. Excellent results were achieved in 9727 cases. Restriction of postoperative effort does not influence the outcome, but surgical technique which fortifies the posterior inguinal canal wall without tension will prevent recurrence. Polyester fiber mesh provided such competence in 3083 patients. For the patient who has only an indirect hernia, transfer of the rectus abdominis tendon to the superior pubic ligament produces a buttress which will disrupt.—Carroll J. Bellis, M.D., Long Beach, Calif.: *International Surgery,* 52:107-110, August, 1969.

Evaluation of Frozen Sections Using the Cryostat in a Community Hospital

Analysis of 3986 Consecutive Cases

James W. Funkhouser, M.D., Melvin Oosting, M.D., Michael Kelly, M.D., and William J. Straughen, M.D.

IT HAS LONG BEEN recognized that one of the major limitations of the use of the frozen section in the rapid diagnosis of tissue removed surgically has been the technical shortcoming of the procedure. It is our experience that the use of the cryostat, introduced into surgical pathology only recently,[1,2] has eliminated this major objection. The cryostat is essentially a cold chamber containing a microtome in which fresh tissue can be sectioned at 6 microns without preliminary fixation.

The use of the rapid frozen section for establishing a histopathologic diagnosis during a surgical procedure has been in existence for over 75 years in this country. Its first use is credited to Welch, who in 1891 performed the first frozen section on a benign breast lesion removed during surgery by Halstead at Johns Hopkins Hospital.[3] Acceptance of this procedure has varied among pathologists and those included among the less enthusiastic are Ewing,[4] Warthin,[5] Breuer,[6] and Simpson.[7] The latter report initiated from this institution 32 years ago. It is generally believed that this procedure has reached a high level of accuracy; however, statistical reports on its routine use are few.[3,6,8-15]

It is the purpose of this communication to report on 3986 consecutive frozen sections using the cryostat, covering the years 1963 through 1968.* To the best of our knowledge, this represents the largest consecutive series in the literature.

Method

The biopsy specimen removed in surgery is transported to the pathology laboratory by surgical personnel. Since the pathology laboratory is adjacent to surgery, this transportation takes approximately one minute. The gross specimen is examined by one of the four staff pathologists with an assigned resident, and a representative portion is selected for cryostat sectioning.* The tissue is embedded on the metal chuck using a commercial preparation.** Freezing is hastened by direct application of freon.***

The cut sections are fixed in alcohol-formalin and then stained with hematoxylin and eosin. On occasion, additional sections are prepared for staining with hematoxylin-phloxine-saffron to supplement the routine stain. Stained sections are mounted and retained for permanent reference. All tissue sections are prepared by a technologist. Time for preparation and microscopic interpretation averages 10 minutes, only 3 to 4 minutes longer than by the conventional method. The pathologic diagnosis is relayed directly to the surgeon by an intercommunication system. The tissue is reported as either benign or malignant,

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*Part of this study has been reported previously.[16]
Submitted August 14, 1969.

* International-Harris, Model CT
** Tissue-Tek, Ames Company
*** Freon 22, Virginia Chemicals, Inc.

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with a more specific diagnosis in a large percentage of cases. The exact verbal report is recorded and initialed by the pathologist in a log book. The sectioned side of the tissue block used is marked lightly with 2 percent mercurochrome so as to guide the technologist in later paraffin embedding and to insure that the next section will serve as the permanent paraffin control. This permanent paraffin section is compared with the cryostat section and serves as the control.

Results

The results of 3986 consecutive frozen sections using the cryostat are shown in Table 1. The percentage of accuracy in frozen section diagnosis is shown for each tissue, with an overall accuracy of 98.3 percent. This compares favorably with the previously reported figure of 98.1 percent from this laboratory.[16] The most common tissue examined was from the breast, which comprised 58 percent of the total. The tissue with the least accuracy was the brain-spinal cord and mouth. A total of 69 errors were made (Table 1). Cases classified as errors included those reported as benign or malignant by frozen section and later reclassified after examination of the permanent paraffin section. There were only eight cases classified as false positives where an erroneous diagnosis of malignancy was made when the lesion was benign. In none of these cases was treatment instituted which was harmful to the patient. Errors were further categorized into faulty interpretation and sampling errors (Table 2). The latter refers to situations in which the significant diagnosis was present in tissue other than that selected by the pathologist for frozen section. Of the 69 errors, 35 were of the interpretative type and 34 due to sampling.

Requests for delayed 24-hour reports by the pathologist in which he gave a tentative correct diagnosis based upon the permanent paraffin sections were not included among the errors. However, those cases in which he requested the delayed report without a tentative correct diagnosis or gave no diagnosis (indeterminate) were then classified as errors. The former group consisted of 43 cases and, if they were to be considered as errors, it would add 1.1 percent, with an overall accuracy of 97.2 percent.

Objectivity of final interpretation of the paraffin section in difficult or questionable cases was maintained by consultation with other pathologists. All neurologic cases were reviewed by a consulting neuropathologist, and his diagnosis was accepted as final.

It should be emphasized that many of the most difficult diagnostic cases are submitted for frozen section and, even with careful study, there are differences of opinion on permanent sections. In such cases, the diagnosis of the outside consulting pathologist was taken as final.

Discussion

It has been our experience with this six year retrospective study of frozen sections using the cryostat that this instrument has aided tremendously in making this procedure a reliable diagnostic tool. The quality of the preparations are in

TABLE 1. Frozen Section Diagnosis on 3986 Cases

Source	# Specimens	% Malignant Tumors	% Benign Pathology	% False Negative*	% False Positive*	Total Accuracy
Breast	2315	15.9	84.1	0.6(14)	0	99.4
Lymph Nodes	243	21.8	78.2	2.5(6)	0.4(1)	97.1
Skin	222	26.5	73.5	3.6(8)	0	96.4
Thyroid	189	6.8	93.2	1.6(3)	0	98.4
Colon-Rectum	108	20.4	79.6	4.6(5)	0.9(1)	94.5
Ovary	108	15.7	84.3	0.9(1)	0	99.1
Uterine Curettings	90	6.6	93.4	0	1.1(1)	98.9
Brain-Spinal Cord	87	58.6	41.4	9.2(9)	0	90.8
Lung	80	33.7	66.3	2.5(2)	1.3(1)	96.2
Peritoneum-Mesentery	69	42.3	57.7	2.8(2)	1.4(1)	95.8
Stomach	69	17.4	82.6	1.5(1)	1.5(1)	97.0
Soft Parts	62	11.3	88.7	1.6(1)	1.6(1)	96.8
Cervix	37	32.4	67.6	5.4(2)	0	94.6
Urinary-Male Genitalia	36	41.6	58.4	0	0	100.0
Bone	31	41.9	58.1	3.2(1)	0	96.8
Liver	30	26.6	73.4	3.3(1)	0	96.7
Small Intestine	28	17.7	82.3	0	0	100.0
Parotid	23	8.7	91.3	0	0	100.0
Mouth (Tongue, etc.)	21	38.1	61.9	9.5(2)	0	90.5
Miscellaneous	138	16.6	83.4	2.2(3)	7.0(1)	97.1

* Number of errors in parentheses.

most instances equal to or only of slightly less quality than permanent sections with paraffin embedding. In the past it was difficult to prepare adequate sections by the conventional method on certain tissues, namely, lymph nodes and thyroid; however, high quality sections have been obtained using the cryostat. The cryostat also eliminates the possibility of losing or exhausting small tissue samples, including needle biopsies, as was frequently experienced using the conventional method.

There are several important facts that have been brought out by this study. In general, sampling errors are unavoidable, as encountered in cases of in situ lobular carcinoma of the breast, in situ carcinoma in the tip of a colonic polyp, and in situ carcinoma of the cervix, but other types of errors may be reduced by an even more cautious gross examination.

Neuropathology is a subspecialty and it would be expected that the interpretations of the general pathologist might be less accurate than those of the neuropathologist. However, in this area two points are brought out by this study which will increase accuracy. One is a knowledge of the clinical setting prior to frozen section interpretation and the other is the knowledge that many specimens are inadequate. In these circumstances the pathologist should not be hesitant to request more tissue. Since the luxury of having a neuropathologist is limited to a few large centers, the general pathologist must continually strive to increase his competency in this area. The 90 per cent accuracy in this area (Table 1) would appear acceptable.

The overall accuracy of 98.3 percent compares favorably with reports in the literature on routine frozen sections which range from 89 percent[6] to 98 percent.[9,11,15] It cannot be overemphasized that those interpretating frozen sections should not hesitate to say they do not know. If an error is made, a false negative is less hazardous. If a benign condition is misinterpreted as malignant, it could lead to unnecessary surgery, which should be kept at a very low incidence. The eight false positives in this study, which fortunately led to no unnecessary surgery, would appear acceptable.

The accuracy level is related to the frequency of interpreting frozen sections and one's training. The training in surgical pathology today is such that the previous attitudes of discouraging the general pathologist from doing frozen sections is no longer applicable.[17] The routine use of the cryostat has fortified this opinion. Factors involved in improving the value and reliability of frozen sections are: (1) high quality preparations with the use of the cryostat; (2) advanced scheduling of frozen sections with clinical information available; (3) qualified histology technologists; (4) direct audio-communication with the surgeon; (5) cooperation with the surgical team by way of advance discussion and examination of selected cases and periodic discussions of frozen section performance; (6) continual retrospective critical analysis of performance; (7) use of staining procedures other than hematoxylin-eosin to enhance interpretation; (8) frequency of performing the procedure; and (9) readily available consultation among staff pathologists. There are very few tissues which do not lend themselves to adequate preparation with the use of the cryostat and the inherent errors in the method are now those of sampling and interpretation.

Table 2. Errors Due to Interpretation and Faulty Sampling of Frozen Sections

Source of Tissue	Errors of Interpretation	Errors of Sampling
Breast	7	7
Colon	3	3
Skin	6	2
Thyroid	1	2
Lung	3	0
Brain-Spinal Cord	6	2
Lymph Node	7	0
Stomach	2	0
Soft Parts	2	0
Nose	2	0
Cervix	0	2
Uterine Curettings	1	0
Liver	1	0
Peritoneum-Mesentery	1	2
Ovary	1	0
Bone	1	0
Tongue (Mouth)	1	1
Nasopharynx	1	0
Orbit	1	0

Summary

A six year analysis of 3986 consecutive frozen sections using the cryostat is presented. The overall accuracy is 98.3 percent. Errors due to interpretation and sampling were approximately equal. The most frequently examined tissue was the breast (58.1 percent). The interpretation of sections from the brain-spinal cord and oral cavity represented the lowest degree of accuracy (90 percent). Technical shortcomings of the conventional frozen section are mainly eliminated with the use of the cryostat.

Acknowledgement: We wish to thank Doctors Robert E. Zipf and C.E.M. Wenyon, who participated in the earliest years of this study.

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EXERCISE-INDUCED ASTHMA. — The condition of exercise-induced asthma has been described surprisingly infrequently in adults. These patients are probably latent asthmatics in whom exercise produces the only stimulus to bronchoconstriction. It is well known that bronchoconstriction may be produced in asthmatic subjects by exercise and that this effect may be blocked by prior administration of sympathomimetics, steroids, and disodium cromoglycate. Once bronchoconstriction has been initiated, however, it is usually unresponsive to pharmacological agents.

The precise cause of the bronchoconstriction after exertion is not understood. Any theory must take into account the response to drugs mentioned above, the time relationship to exercise, and the delay of two hours before recovery is complete. In addition, the diminishing effect of repeated exercise over the course of a day, the absence of any bronchoconstriction after hyperventilation induced by rebreathing, and the occasional fall in F.E.V., on voluntary hyperventilation must be explained.

Tests in three patients with asthma occurring only on exertion showed that F.E.V. fell progressively on exercise, to reach a minimum after 10 minutes. All patients showed a striking metabolic acidosis, with an accumulation of the products of anaerobic metabolism. — A. Seaton, M. B., Glyn Davies, B. Sc., D. Gaziano, M. D., and R. Osborne Hughes, M. B., Liverpool, England: *British Medical Journal,* 3:556-558, Sept. 6, 1969.

Effects of Cephalothin In Term Pregnancy

Marvyn H. Youkilis, M.D.

SODIUM CEPHALOTHIN, 7-(thiophene-2-acetamido) cephalosporanic acid, is a semisynthetic antibiotic which has been used extensively in the therapy of gram-negative and gram-positive infections with few untoward reactions.[1] It has previously been shown to pass the human placenta to the fetus[2, 3] as well as being absorbed in a retrograde manner into the maternal blood after transabdominal injection into the amniotic fluid.[4]

There is now considerable evidence that high concentrations of cephalothin in the blood, particularly in patients with azotemia and hypoalbuminemia, may induce a non-immune positive direct antiglobulin test. This appears to be the result of non-immune binding of a cephalothin-globulin-complex to the surface of the erythrocyte.[5, 6] It has not been demonstrated to be associated with any hemolytic or adverse effect, although one out of twenty Coombs positive subjects in the report of Gralnick, et al, developed neutropenia. However, this patient was on a regimen of cephalothin, chlorothiazide, and ampicillin trihydrate, all of which may cause neutropenia. At present, the chief significance of the phenomenon is that it might complicate blood banking procedures since erythrocytes from a cephalothin treated patient, when used on the minor side of the cross-match, might be Coombs positive and thus confuse a Coombs cross-match. Theoretically, cephalothin administered to a woman prior to delivery might also cause a positive direct Coombs test in the newborn, thereby producing difficulty in the diagnosis of hemolytic disease. This study was undertaken primarily to determine what effect cephalothin, when administered intravenously to the human pregnant subject in the last trimester of pregnancy, would have upon the direct Coombs test of the newborn.

Materials and Methods

Twenty volunteer subjects admitted due to spontaneous rupture of membranes in the third trimester of pregnancy, all Rh positive, were selected for the study. None of the subjects had known renal disease. Prior to the administration of cephalothin, a negative direct Coombs test was obtained in each case. Cephalothin was administered by intermittent intravenous injection, 1 gm. every four hours, until delivery was effected. Obstetric management was not changed for the study in that some patients progressed to spontaneous labor and in others labor was induced within 24 to 48 hours after admission. Prior to each dose of cephalothin, a maternal blood specimen was obtained for determination of residual antibiotic concentration.

At the time of delivery, irrespective of its chronologic relationship to the last dose of antibiotic, maternal blood was obtained by venipuncture for a repeat direct Coombs test as well as determination of antibiotic level. Cord blood from the infant was also obtained for antibiotic concentration as well as an initial direct Coombs test. A repeat direct Coombs test was performed on the infant on the third day of life.

Serum samples were frozen and forwarded to the Eli Lilly Company for antibiotic level determinations. Direct Coombs tests were performed by the University of Cincinnati Blood Bank.

Results

Direct Coombs tests performed on maternal and newborn blood specimens were consistently negative. Neonatal weights varied between 2041 gm. and 4026 gm. No untoward effects attributable to cephalothin were noted in the neonatal period.

In 50 out of 53 determinations, cephalothin was undetectable in maternal serum four hours after intravenous administration of 1 gm. Twelve patients received 3 gm. or less of cephalothin prior

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Table 1. Maternal Serum Keflin Concentration (μg/ml) Prior to Second and Subsequent Doses

2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
2.48	0	0.89	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0									
0	0	0	0	0										
0	0	0	0											
0	0	0	0											
0	0	0	0											
0	0	0	0											
0	0	0	0											
0	0													
0														
6.98														
0														
0														
0														

to delivery. The remaining eight patients received 4 gm. or more, and of the latter, one received a total of 16 gm.

The maternal serum levels of cephalothin prior to the second and all subsequent doses of cephalothin are listed in Table 1. There is no evidence that cephalothin, administered by this route and this dose schedule, tends to accumulate in the serum of pregnant women in the last trimester of pregnancy. Figure 1 indicates the maternal and fetal serum concentrations of cephalothin at the time of delivery with respect to the last dose of maternally administered cephalothin.

Summary

The cord and maternal serum cephalothin concentrations following intermittent intravenous administration of cephalothin, 1 gm. every four hours, agree essentially with previously published data[4] on single 1 gm. injections with one exception. In the study of Mac Aulay and Charles it was also reported that the average maternal concentration of cephalothin was 0.08 μg/ml five hours after administration of 1 gm. intravenously.

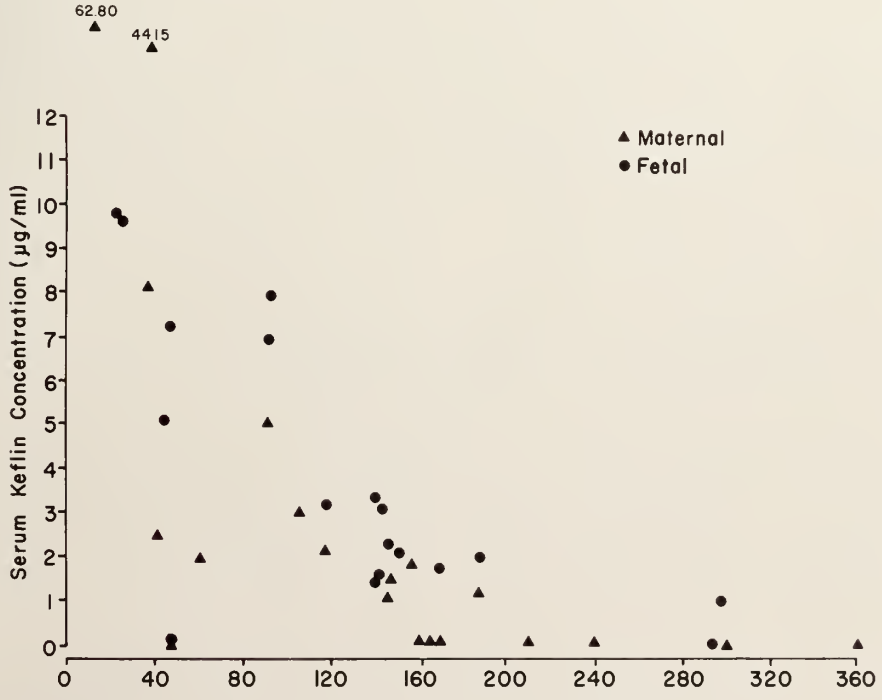


Fig. 1. Time After Last Dose of Keflin (Minutes)

In the present study, residual cephalothin concentrations were undectable in maternal serum in almost all instances four hours after intravenous administration of 1 gm. of cephalothin as shown in Table 1. This discrepancy is most likely due to the fact that the previously reported 0.08 μg/ml concentration was an extrapolation rather than a precisely determined value, since the analytic method employed by Mac Aulay and Charles is capable of detecting levels only as low as 0.20 μg/ml. This hypothesis is further supported by the fact that in one subject of the present study cephalothin failed to accumulate in maternal serum even after 16 consecutive 1 gm. intravenous doses given at four hour intervals.

In addition, the present study failed to demonstrate an effect on the fetal direct Coombs attributable to maternally administered cephalothin at the dosage used. It is concluded that cephalothin may be used with relative safety when indicated in late pregnancy, but that a positive direct Coombs test of the maternal patient or her offspring must be interpreted cautiously.

Generic and Trade Name of Drug
Sodium cephalothin—Keflin (Lilly)

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TREATMENT OF DEEP VEIN THROMBOSIS (I). — Thirty patients with deep vein thrombosis of the legs of less than four days' duration were allocated at random to treatment with heparin, streptokinase, or Arvin under laboratory control. When the fate of the thrombi was assessed by objective technics—phlebography and the ^{125}I-labelled fibrinogen test—the incidence of complete thrombolysis was greatest in the streptokinase group. Complications arose during treatment in each group but were least with Arvin. The natural history of the disease favours clinical but not always anatomical recovery. — V. V. Kakkar, F.R.C.S., C. Flanc, F.R.A.C.S., C. T. Howe, F.R.C.S., M. O'Shea, M.D., and P. T. Flute, M.D., London, England: *British Medical Journal*, 1:806-810, March 29, 1968.

TREATMENT OF DEEP VEIN THROMBOSIS (II). — Twenty-one patients who had an acute episode of thrombosis in the deep veins of the legs were studied by a new technique of ascending functional cinephlebography 6 to 12 months after the episode of thrombosis.

If the condition was diagnosed within 36 hours and the thrombus was dissolved rapidly valve function was preserved. When diagnosis was delayed there was a very great risk of permanent damage to the valves. — V. V. Kakkar, F.R.C.S., C. T. Howe, F.R.C.S., J. W. Laws, F.R.C.P., and C. Flanc, F.R.A.C.S., London, England: *British Medical Journal*, 1:810-811, March 29, 1969.

Pregnancy and Cystic Fibrosis Of Lungs and Pancreas

A Case Report

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A 19 YEAR OLD white woman was referred to the author in August, 1967 because of pregnancy. This patient had a firmly established diagnosis of cystic fibrosis involving the lung and pancreas with a lifelong history of frequent episodes of respiratory infection. Chronic cough and sputum production had been longstanding symptoms. The diagnosis of cystic fibrosis was established by the presence of bilateral upper lobe lung infiltrates, absence of pancreatic enzymes in the duodenal drainage, and a low serum carotene. The family history supported this diagnosis. Her mother had two children from a previous marriage, a boy and a girl, with no respiratory difficulty of any kind. Two of the four children from the patient's father had died of a similar illness, and a ten year old brother has cystic fibrosis. At the time of her initial visit, the patient was taking a pancreatic enzyme preparation.* Her activities and diet were unrestricted. She stated her last menstrual period was the first week of April, 1967.

Case Report

On examination, she appeared fairly well nourished with pale skin and definite clubbing of the fingers and toes. Her weight was 118 pounds, height 5 ft. 2 inches, pulse rate 80 beats per minute and blood pressure 108/66 mm Hg. Dentition was poor. There was an acneiform rash on the neck, shoulders, and trunk. The chest cage moved fairly well, and the air exchange was good, with fine rales in both upper posterior lung fields. Heart sounds were good, with A2 greater than P2. There was an apical systolic murmur of moderate intensity varying with respiration. The liver and spleen were not palpable. The uterus was enlarged to 4 cm. below the umbilicus. Multiple vulvar venereal warts were present. On September 6, 1967, lung ventilation and diffusing capacities were reported normal except for moderate hyperventilation. The hemoglobin was 12.6 gm per 100 ml, and the white blood cell count 8,500 per cu. mm. Urinalysis was normal. Sputum culture yielded *Staphlococcus aureus,* coagulase-positive; numerous *Neisseria;* and a few *alpha Streptococci.* Serum carotene was 68 mg. per 100 ml. Antinuclear factor was negative. Serum complement was 140.2 ch/50 units per ml. The immunochemical analysis was within normal limits with IgA 120 mg. percent, IgM 85 mg. percent, and IgG 800 mg. percent. An elevated Alpha 2 macroglobulin of 701 and a ceruloplasmin level of 237 were reported.

Her pregnancy proceeded uneventfully except for the continuing problem of productive cough. Repeat pulmonary function studies showed "slightly reduced ventilation compared to the first trimester but with no change in the diffusing capacity." Sputum cultures continued to grow various bacteria and, occasionally, *Candida.* Multiple antibiotics were used.

In November, excessive weight gain was noted and appropriate dietary restrictions were started. On January 3, 1968, the patient was admitted in active labor and, after 8 hours and 34 minutes of labor, low forceps delivery of a 3,690 gram, well developed, female infant with an apgar rating of 9 was accomplished using epidural anesthesia. The infant had no problems in her six day nursery stay. After delivery, the patient was managed in the routine fashion except that intermittent positive-pressure breathing was added.

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*Cotazym (Organon Laboratories)

Submitted September 17, 1969.

The postdelivery film showed some "cystic-like" changes in the right upper lobe suggesting underlying bronchiectasis. At the time of delivery, quantitative and qualitative assessment of the immune mechanism was completed. Immunoglobulins, intereferon response, and complement levels gave no evidence of variance from the normal in maternal serum, cord serum, or amniotic fluid. This suggests that despite persistent significant infection no deterioration of the patient's immune mechanism occurred during the pregnancy.

Discussion

Novy, et al,[1] in their discussion of cystic fibrosis in pregnant women emphasized that patients show clinical evidence of pulmonary decompensation following and during pregnancy. This patient did not show any significant change in pulmonary function. The only subjective symptom was some mild increased shortness of breath on exertion. The deficiency of pancreatic enzymes in patients with cystic fibrosis has been well documented. The patient in this report had no particular dietary problems either before or during her pregnancy. Another primary concern has been the possibility of excessive loss of sodium and chloride in these patients. Certainly, as expressed by Plotts,[4] et al, the obstetrician should be very judicious in the use of diuretics for these potentially hypoatremic patients.

The presence of the longstanding infection could cause abnormalities of the immunologic capacity of the patient. We found no such abnormality either before or after delivery. There was a depressed gamma-g value (5 mg. percent) in the amniotic fluid, which is of questionable clinical significance.

We were concerned about the prolonged use of antibiotics at various times during her pregnancy. However, her youngster was born vigorous and healthy and has shown no evidence of any significant disease in the past year.

Summary

This patient, with cystic fibrosis of lungs and pancreas had a relatively uncomplicated pregnancy and delivery. The only significant problem was that of recurrent cough and production of sputum, which necessitated the chronic usage of antibiotics. Fortunately, no deterioration of her functional pulmonary status occurred. The patient delivered a healthy term infant without evidence of disease.

Generic and Trade Name of Drug
Pancreatic enzyme — Cotazym (Organon, Inc.)

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APOPLEXIA UTERI. — The uteri of 379 women over 50 years of age were studied at autopsy; endometrial hemorrhage, with or without necrosis, was found in 19. These postmenopausal patients had no evidence of hormonal abnormalities that could have given rise to a situation analogous to menstruation. Every patient experienced varying degrees of cardiovascular decompensation for variable periods before death; a background of organic or functional cardiac disease was uniformly present. Hemorrhagic enteropathy was noted in six (31.6 percent) of the subjects displaying the endometrial lesion. The common morphologic features and clinical backgrounds of these entities suggest a similar pathogenetic mechanism: inadequate perfusion of the areas in question appears most likely. The occurence of vaginal bleeding in an elderly female in shock should suggest endometrial ischemia as a possible cause, and it may serve to warn of the development of hemorrhagic necrosis of the bowel. — James J. Daly, M.B., B.Ch., B.A.O., M.Sc., and Karoly Balogh, Jr., M.D., Boston: *The New England Journal of Medicine*, 278:709-711, March 28, 1968.

Presacral Meningocele

Case Report with Discussion

Neil R. Thomford, M.D., Carole A. Miller, M.D., and Neil J. Sherman, M.D.

MENINGOCELES presenting as presacral cysts are dangerous because they are rare, occult, and a source of meningitis. Infection may occur spontaneously or after aspiration or excision of the cyst when its true identity is not suspected. Even carefully planned operations with a correct preoperative diagnosis are hazardous. This report describes a case of presacral meningocele and reviews the clinical findings and management of these unusual lesions.

In 1837 a surgeon, who requested his name be omitted, reported a case of a large cyst of the pelvis in a pregnant woman.[1] The cyst prevented normal delivery of the infant and resulted in death of the mother four days later. At autopsy the cyst was identified as a presacral meningocele. In 1871 Emmet reported a case in which he aspirated a pelvic cyst through the anus.[2] Death resulted from meningitis and the diagnosis of ventral meningocele was established at autopsy. Additional isolated reports preceded Pupovac's description in 1903 of the successful removal of a presacral meningocele through a dorsal incision.[3] In 1943 Coller and Jackson summarized 22 previously reported cases and described a patient of their own in whom a presacral meningocele was identified through an abdominal incision and successfully excised through a posterior midline incision.[4] By 1958 Haddad was able to collect and study a total of 52 case histories of patients with presacral meningocele.

Report of a Case

A 54 year old white male was admitted to The Ohio State University Hospital on March 3, 1969, because of epigastric pain of one week's duration. He had experienced intermittent, dull epigastric pain for 14 years. Attacks of pain characteristically occurred every two to three months, frequently followed a large meal, persisted for one to two hours, and often were associated with nausea and flatulence. The episode of pain which began one week before admission persisted as a steady, dull ache which radiated to his right shoulder and anterior chest. The night before admission he was unable to sleep and "walked the floor all night." He denied jaundice, chills, fever, diarrhea, constipation, weight loss, or other gastrointestinal symptoms.

The patient's past medical history included a "nervous breakdown" in 1950 requiring hospitalization for a period of five months. In 1967 the patient experienced an episode of syncope resulting in an injury to the back of his head with a laceration of the scalp. A review of systems was noncontributory. He denied any genitourinary symptoms.

On physical examination the blood pressure measured 120/66 mm Hg, pulse rate was 100 beats per minute, and the oral temperature 101.2F (38.4C). The mucous membranes were dry, and the skin turgor was less than normal. Abnormal findings on examination of the abdomen included absence of bowel sounds together with palpable tenderness, rebound tenderness, and involuntary muscle spasm in the area of the right hypochondrium and epigastrium. A 3 cm. tender smooth mass in the right hypochondrium moved with respiration and was interpreted as a distended, inflamed gallbladder. Digital examination of the rectum revealed a cystic presacral mass with its inferior margin at the level of the prostrate gland. It displaced the rectum anteriorly and occupied the major portion of the true pelvis. The remainder of the physical examination including the neurologic examination was normal.

Laboratory data were as follows: blood hemoglobin

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16 gm per 100 ml; hematocrit 47 percent; leukocyte count 16,200 per cu mm with 81 percent neutrophils, 13 percent lymphocytes, 5 percent monocytes, and 1 percent eosinophil; serum concentrations of amylase, potassium, chloride, and sodium were within the limits of normal; blood urea nitrogen (BUN) 11 mg per 100 ml; serum creatinine 1.2 mg per 100 ml; and a urinalysis was reported as having a pH of 9.0, specific gravity 1.020, protein 0 gm, sugar 0 gm, and microscopic examination of the sediment was reported as showing no abnormalities. A serologic test (VDRL) for syphilis was reported as nonreactive. An electrocardiogram was reported as normal. Roentgenograms of the chest and abdomen were normal with the exception of a developmental abnormality of the sacrum. A portion of the right side of the sacrum was absent. A diagnosis of acute recurrent cholecystitis was made. In addition, ventral meningocele was suspected because of the presence of a cystic presacral mass together with a congenital abnormality of the sacrum (Fig. 1).

After suitable preparation with intravenous fluids, an abdominal operation was performed, which confirmed the diagnosis of acute cholecystitis. The gallbladder was removed, and an operative cholangiogram was made, which demonstrated normal bile ducts without evidence of calculi or other disease. The remainder of the intra-abdominal examination was normal with the exception of the large cystic mass which filled the true pelvis and projected into the lower abdomen. The mass displaced the rectum and bladder in an anterorsuperior direction. It was not exposed or disturbed.

The patient's recovery after operation was uneventful. During the postoperative period, an intravenous urogram was done which demonstrated anterior displacement of the bladder and minimal lateral displacement of the pelvic portion of the ureters. Fluoroscopy and films following an enema of barium sulfate showed the anterior displacement of the rectum but no other abnormalities. March 14, 1969, a lumbar puncture was done at the level of the third lumbar vertebra. The spinal fluid pressure was 19.5 mm of water. Routine studies of a specimen of spinal fluid were reported as within the limits of normal. Two milliliters of Pantopaque was injected after which roentgenograms were made confirming the diagnosis of a presacral meningocele (Figs. 2 and 3). The patient was dismissed from the hospital on March 30, 1969. Removal of the meningocele was considered, and he was advised to return for further study. He failed to keep his appointment.

Comment

Presacral meningocele is a meningeal cyst of the pelvis due to agenesis of a portion of the anterior sacrum. The diagnosis is most often made during the third decade of life, but the ages of reported patients have ranged from three months to 55 years. Eighty-five percent of patients are female. The defect of the sacrum is usually located laterally and in most instances the cyst is confined to the pelvis. However, it may herniate through the sciatic foramen and present posteriorly as a



Fig. 1. Photograph of roentgenogram showing cyst of pelvis and defect of the sacrum charactecteristic of presacral meningocele.



FIG. 2. Photograph of roentgenogram made with patient standing. Contrast medium outlines inferior border of the meningocele.



FIG. 3. Photographs of roentgenograms made with patient in prone position, A (left) and supine position, B (right). Contrast medium outlines anterior and posterior boundaries of the meningocele.

mass along the inferior margin of the gluteus maximus muscle.

The majority of presacral meningoceles are discovered as a result of symptoms caused by the lesion. In only a few cases has the lesion been described as an incidental finding. The most common presenting complaint is constipation. Urinary tract symptoms and nondescript complaints referable to the back and lower extremities are also common. Menstrual abnormalities are a frequent reason for discovery of a presacral meningocele, but the relationship of the cyst to dysmenorrhea, sterility, or vaginal discharge is often uncertain. Severe headache following pelvic examination and concomitant headache and abdominal pain have suggested the diagnosis in isolated instances. In a few cases, presacral meningoceles have been discovered only when they prevented normal delivery of an infant.

Physical findings in most cases are limited to the examination of the rectum. A smooth cystic presacral mass causes anterior displacement and compression of the rectum. The mass is fixed in position. It is often slightly compressible and steady pressure may cause headache. An impulse may sometimes be felt when the patient coughs. If large in size, it may be palpable in the lower abdomen or herniate through the sciatic foramen and present posteriorly as a mass in the buttock. In rare instances, an extension of the cyst has presented as a polyp in the rectum or a mass in the perineum. Patients in whom meningitis has developed will have the classical findings of that complication. Neurologic findings are otherwise rare and confined to minimal sensory changes. In Haddad's review of 53 cases, there were associated congenital malformations in 22 cases. These included deformities of the spine other than those of the sacrum, bicornuate uterus, duplication of the vagina and uterus, another meningocele, clubfoot, bilateral bifid renal pelvis, and bilateral Petit's hernia.

The differential diagnosis of a presacral mass must include a variety of presacral tumors of which dermoids and chordomas are most common.[8] In addition, inflammatory, neurogenic, osseous, vascular, and metastatic tumors may occur in the presacral space. The findings of a mass in the buttock along the inferior margin of the gluteus maximus muscle should suggest the possibility of a sciatic or perineal hernia as well as a presacral meningocele presenting posteriorly.

Plain roentgenograms of the abdomen may show a cystic mass in the pelvis. In addition, displacement of the bladder identified by an intravenous urogram or displacement of the rectum demonstrated by a barium enema examination will aid in confirming the size and location of the cyst. However, to establish the diagnosis preoperatively, a myelogram is essential. In some cases an oil myelogram may fail to show the cyst if the stalk is too narrow to allow passage of oil into the cyst. It may be necessary in these cases to position the patient with his head down and inject oxygen into the subarachnoid space.

The defect in the sacrum is often large and usually laterally located. The remaining sacrum resembles a scimitar in shape and the term "scimitar sacrum" has been used to describe its appearance. When this classical defect of the sacrum exists, it is virtually pathognomonic of presacral meningocele. Although the defect in the sacrum is often large, the stalk connecting the lumbar subarachnoid space and the presacral cyst is usually narrow. The cyst itself is thin walled and in several cases a progressive increase in the size of the sac has been observed. In 11 (21 percent) of the 53 cases collected by Haddad a part of the cauda equina, glial tissue, or other neurogenic tissue was found within the meningocele. This knowledge is important when decisions for the removal of presacral meningoceles are made.

Of the 53 cases collected by Haddad, 15 were untreated. A total of 37 patients had either aspiration or excision of the lesion. The overall mortality rate was 43.4 percent. This astonishing mortality rate for a benign lesion was attributed to two major factors. Seven of 15 untreated patients died and five of the seven deaths were the result of meningitis. Sixteen of the 37 treated patients died. Twelve of the 16 deaths were caused by meningitis; in 8 of the 12, meningitis followed aspiration of the meningocele through the vagina or rectum. Thus, failure to perform an operation when the lesion is recognized and misdirected treatment because of misdiagnosis are associated with great risk of life. When a presacral meningocele is discovered in children or young adults, and especially when the patient is female, operation appears indicated. Whether an asymptomatic, 54 year old male should undergo operation for presacral meningocele is less certain. The preferred treatment is a posterior transsacral approach with division of the stalk and closure of the lumbar subarachnoid space.[7, 9] The sac need not be excised.

Summary

When the identify of a presacral meningocele is not suspected, misdirected diagnostic or therapeutic procedures may result in meningitis. In other instances meningitis develops spontaneously. Palpation of a presacral cyst and roentgenographic evidence of a defect in the sacrum should suggest the diagnosis. When myelography has confirmed presence of the meningocele, a transsacral approach may be used to ligate its stalk.

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IMPACT OF CIVILIZATION ON HUMAN BIOLOGY.—Among the numerous definitions of the human species that one comes across from time to time, is the following: "Man is the only animal that eats when it is not hungry and drinks when it is not thirsty." This definition is probably fairly accurate for modern man, but it certainly does not hold for his ancestors living under pre-neolithic conditions. Whereas it is a common fallacy that Stone Age people hardly ever had enough to eat (from the biological standpoint this would seem to be most unlikely), it is equally improbable that they ate too much. This was not because food was in short supply, but because natural regulatory mechanisms prevented overeating—a practice which is biologically unsound for several reasons. Other animals in the wild state do not eat more than they require for healthy living even when food is especially abundant, and obesity is extremely rare in nature; nor do human beings become obese when living as hunter-gatherers under Stone Age conditions. —Stephen Boyden, Canberra, Australia: *The Australian Journal of Experimental Biology and Medical Science,* 47:287-298, June, 1969.

FEBRUARY IS "HEART MONTH," and we plan to devote that issue of *The Journal* to a series of papers written by nationally recognized authorities at the request of the American Heart Association. These have been made available to us through the Ohio State Heart Association. Watch for this outstanding issue of The Journal.

Concomitant Pernicious Anemia and Thyrotoxicosis

A Case Report and Discussion

John M. Douglass, M.D., and Boris Catz, M.D.

THIRTY YEARS AGO, and even before, the medical literature reported significant numbers of patients with concomitant thyrotoxicosis and pernicious anemia. Yet this association was virtually ignored until the past ten years. Even today, most textbooks of hematology and endocrinology either do not mention the combination or say that it occurs but rarely.

Two of the more recent papers,[2,5] have not only pointed out the occurrence of hyperthyroidism and pernicious anemia in the same patient but have also shown that antibodies to gastric cytoplasm are common in patients with thyrotoxicosis. Conversely, antibodies to thyroid cytoplasm occur frequently in persons with pernicious anemia.

The following report illustrates a case of thyrotoxicosis occurring in a patient with pernicious anemia. The subsequent discussion attempts to clarify the relationship between these two diseases.

Case Report

A 51 year old white man with a past history of pernicious anemia entered Los Angeles County General Hospital on March 3, 1966, complaining of increased sweating, weakness, weight loss, and nervousness. He had lived in Hungary until 1941, when he was taken prisoner by the German Army. He suffered severe dietary deprivation and physical abuse until his release in 1945. Several months prior to his release, he first noted spasticity of both legs. Upon his return home, he saw his physician, who made a diagnosis of pernicious anemia. He was treated with blood transfusions and liver extract, which relieved his anemia and improved his spasticity to some extent.

He received intermittent treatment with liver extract and blood transfusions until 1954, when he came to the United States. In 1957, he was hospitalized with severe anemia (Hgb 2.5 Gms. per 100 ml.) and exacerbation of his spasticity. Vitamin B_{12} injections relieved the anemia, but the spasticity did not improve. Hospitalization took place again in 1962, when he redeveloped severe anemia after having stopped his injections of B_{12} for several years. He was treated until 1963, when he stopped his clinic visits.

The patient was seen at Los Angeles County General Hospital in March, 1966 complaining of nervousness. The examining physician noted exophthalmus and questioned the patient further. He described increased sweating, weakness, and heat intolerance, which had gradually worsened during the previous two years. He had also noted enlargement of his eyes and neck in the preceding six months.

There was no family history of pernicious anemia or hyperthyroidism, and the review of systems was essentially negative.

The patient was a nervous middle-aged white man with protuberant eyes and a spastic gait. His blood pressure was 120/70 with his pulse rate 112 beats per minute with regular rhythm. He had bilateral exophthalmus with slight lid lag and stare. His thyroid was nodular and enlarged to three times its normal size, with the right lobe more prominent than the left. He had smooth, warm, skin and hairless arms and legs. There were brawny edema and darkening of both pretibial areas. Severe spasticity of both legs and 4+ deep tendon reflexes were also noted. Babinski's and sustained ankle clonus were present bilaterally, while his sensation to pin prick, cold, heat, and vibration were markedly decreased in both legs.

His complete blood count, urine, blood sugar, BUN, sodium, and potassium were normal. His gastric aspirate was negative for free acid after histamine stimulation. His Schilling test showed less than 1 percent excretion before and 9.8 percent after intrinsic factor. However,

Submitted September 25, 1969.

The Authors

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his B_{12} and folic acid levels were normal. Serum protein bound iodine (PBI) was 15 mcg per 100 ml (normal 4 to 8). The thyroid binding globulin was 25.5 mcg per 100 ml (normal 12 to 20), while T_3 and cholesterol were within normal limits. Assay for long acting thyroid stimulating hormone was positive, while determination of thyroid antibodies and thyroid stimulating hormones were negative. Radioactive iodine uptake was 24 percent in 5 hours and 19 percent in 24 hours.

He was diagnosed as having pernicious anemia in remission, subacute combined spinal cord degeneration, and hyperthyroidism. The patient was started on propylthiouracil, 200 milligrams four times a day; 2 grains of thyroid a day; Vistaril, 50 milligrams four times a day; Benadryl, 50 milligrams four times a day; and vitamin B_{12} injections once a month.

The patient's heart rate returned to normal, his nervousness and depression improved, and he began to gain weight. After discharge from the hospital, he continued to improve while being followed in the thyroid clinic for 14 months. Definitive therapy was then given with I^{131} in two doses (10 and 15 millicuries) two months apart. He is presently asymptomatic on treatment with desiccated thyroid 3 grains a day, and monthly injections of 1,000 micrograms of B_{12} (See Table 1).

Discussion

When pernicious anemia and thyrotoxicosis occur together in a patient, it is usual for the thyrotoxicosis to precede the pernicious anemia. In this case the patient developed both the hematologic and neurologic manifestations of pernicious anemia 21 years before the onset of thyrotoxicosis. Although vitamin B_{12} therapy reversed his abnormal blood picture, it did not alleviate his neurologic disease. It was interesting to find that his vitamin B_{12} level was still normal after three years with no therapy. This was not due to the patient's developing an ability to absorb B_{12} but was probably because the B_{12} stored in the patient's liver during therapy had not yet been exhausted. His folic acid level was normal, as might have been expected, for pernicious anemia patients absorb this vitamin normally. The radioactive iodine uptake was unusual, indicating a rapid turnover suggestive of hyperthyroidism masked by an increased iodide pool.

Pernicious anemia and thyrotoxicosis occur together in a significant number of cases. On reviewing 3,441 patients with pernicious anemia, 82 or 2.4 percent had concomitant thyrotoxicosis.[2-6] This compares with an incidence of .75 percent in normal controls. The increased incidence probably reflects a similar auto-immune lesion that occurs in both diseases. As evidence of this, one paper reports that patients with pernicious anemia but without overt thyroid diseases had an incidence of antithyroid antibodies of 45 percent, compared with only 13 percent for normal controls.[2] Conversely, Williams, et al (1966) demonstrated antibodies to gastric cytoplasm in 37.5 percent of 40 thyrotoxic patients as compared to 10 percent in matched normal controls.[5]

It is thought that the association of thyroid and gastric mucosal diseases may reflect the closeness of developmental origin of these tissues. Despite their common embryologic origin, however, gastric parietal cell and thyroid antigens are immunologically distinct. It is not known why a patient who develops antibodies to thyroid also develops antibodies to gastric mucosa and vice versa.

It is interesting to note that this patient developed pernicious anemia at a very young age after severe psychological and physical stress. Thyrotoxic patients often present symptoms fol-

TABLE 1. 51 Year Old White Man with Past History of Pernicious Anemia. Chief Complaints, Weight Loss, Nervousness, Increased Sweating.

Diagnosis: (1) Pernicious Anemia in Remission
(2) Subacute Combined Spinal Cord Degeneration
(3) Hyperthyroidism

	1966 3/23	4/5	5/18	10/19	1967 2/18	5/10	6/26
PBI	15 microgms%		7.4	6.4	10.5	6.6	
Chol.	202 mg%			310		204	
I^{131} Uptake		5 hr.-24%		Thyroid			
		24 hr.-19%		Suppression: 24 hr.-60%			
Exoph.		OD 22.5		OD 25.0			
Meas.		OS 20.5		OS 22.5			
Weight	125		138½	144	140	151	
LATS	Present						
TSH		$\overline{0}$					
Therapy	PTU (Prophylthiouricil)					given	
	Benadryl					10 Mc	
	Thyroid					I^{131}	
	B_{12}						
	Vistaril						

lowing a severe psychologic stress. Perhaps a similar pathologic mechanism is involved in the initiation of both diseases.

In a patient with thyroid disease it is suggested that the physician check for concomitant pernicious anemia, and in a patient with pernicious anemia it is further suggested that he check for concomitant thyroid disease.

Summary

A case of pernicious anemia and thyrotoxicosis occurring together in a 51 year old white man is reported.

A review of the literature and a discussion follow, in which it is noted that thyroid disease and pernicious anemia occur together in a significant number of patients. Immunologic cross reactions between thyroid and gastric tissue seem to be the reason for this.

It is suggested that thyroid function be assessed in patients with pernicious anemia and gastric function evaluated in patients with thyrotoxicosis.

Generic and Trade Names of Drugs

Hydroxyzine pamoate — Vistaril (Pfizer)

Diphenhydramine hydrochloride — Benadryl (Parke-Davis)

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SUDDEN DEATH. — The evidence reviewed supports the notion that fatal cardiac arrhythmias, with or without associated myocardial infarction, may often be attributable to undamped autonomic discharges in response to either afferent information from below, to impulses from higher integrative levels of the brain involved in adaptation to life experience, or to both. Among the patterns of response are those in which the central excitatory state activates both cholinergic and adrenergic pathways. Thus, it appears that the regulatory activity of the autonomic nervous system is manifest, not by the simple antagonism of sympathetic and parasympathetic discharges, but by a coordinated patterning of impulses in both components. In the musculoskeletal system, smooth synergistic responses without excessive irritability are achieved through a well-coordinated inhibitory network. Similarly, satisfactory visceral control appears to require an autonomic inhibitory network operating at afferent, integrative, and efferent levels. Regulatory inhibition appears to be enhanced in situations that tend to concentrate attention on purposeful action and to be diminished in situations that are interpreted as overwhelming and without hope, such as situations of total social exclusion, of hopeless dejection, or of sudden fear. Under such circumstances, the loss of regulatory inhibition may provide a mechanism of death. — Stewart Wolf, M.D., Oklahoma City: *Modern Concepts of Cardiovascular Disease,* 6:29-34 (June) 1969.

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Warnings—Watch for the earliest manifestations of thrambotic disorders (thrombaphlebitis, cerebrovascular disorders, pulmonary embalism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reparted in April 1968[1,2] estimate there is a seven- to tenfald increase in mortality and marbidity due to thrambaembalic diseases in wamen taking aral contraceptives. In these cantralled retrospective studies, involving 36 reported deaths and 58 haspitalizatians due to "idiopathic" thrambaembolism, statistical evaluation indicated that the differences observed between users and nan-users were highly significant. The conclusions reoched in the studies ore summarized in the toble below:

Comparison of Martality and Haspitalizatian Rates Due to Thrombaembolic Disease in Users and Non-Users af Oral Cantraceptives in Britain.

Categary	Martality Rates		Haspitalizatian Rates (Marbidity)
	Age 20-34	Age 35-44	Age 20-44
Users af Oral Cantraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No camparable studies are yet availoble in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spantaneously occurring thromboembolic disease may differ.

Discantinue medicatian pending examinatian if there is sudden partial or complete loss of vision, or sudden onset of praptosis, diplapia or migraine. Withdraw medicatian if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demanstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility af pregnancy should be considered at the first missed period.

A small fraction af the hormone agents in aral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannat be determined at this time.

Precautions—Pretreatment physical examination shauld include special reference ta the breasts and pelvic organs, and a Papanicolaou smear.

Endacrine and possibly liver functian tests may be affected by Ovulen. Therefore, it is recammended that such tests if abnarmal be repeated after the drug has been withdrawn for twa months.

Pre-existing uterine fibromyomas may increase in size under the influence af pragestagen-estrogen preparations.

Because these agents may cause some degree of fluid retentian, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful abservation.

In breakthraugh bleeding, and all irregular vaginal bleeding, consider nonfunctianal causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history af psychic depressian and discantinue the drug if severe depression recurs.

Any passible influence of prolonged Ovulen therapy an pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucase talerance has occurred in a significant percentage of patients on oral cantraceptives. The mechanism of this decrease is abscure. For this reasan, diabetic patients shauld be observed carefully while receiving Ovulen.

Because af the effects of estrogens on epiphyseal closure Ovulen shauld be used judiciously in young patients in wham bane grawth is nat camplete.

The age of the patient canstitutes na absalute limiting factor, althaugh Ovulen therapy may mask the onset af the climacteric.

The pathalagist should be infarmed af Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciation has been shawn between use of oral contraceptives and the following serious adverse reactions: thrambophlebitis, pulmanary embolism.

Although available evidence is suggestive of an associatian, such a relatianship has been neither canfirmed nor refuted for the fallawing serious adverse reactions: cerebravascular accidents, neura-acular lesians, e.g., retinal thrambasis and optic neuritis.

The following adverse reactians are known to occur in patients receiving aral cantraceptives: nausea, vomiting, gastrointestinal symptams (such as abdominal cramps and bloating), breakthraugh bleeding, spotting, chonge in menstrual flow, amenorrhea during and after treatment, edema, chloasmo or melasma, breast changes (tenderness, enlargement, secretian), chonge in weight, changes in cervical erosion and cervical secretians, suppression of loctation when given immediately post portum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mentol depression.

Although the following odverse reactions have been reported in users of orol contraceptives, an associotion hos been neither confirmed nor refuted: anovulotion post treotment, premenstruol-like syndrome, changes in libido, changes in oppetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, bockache, hirsutism, loss of scalp hoir, erythemo multiforme ond nodosum, hemarrhogic eruption, itching. The following laboratory results may be oltered by oral contraceptives: hepatic function: increosed sulfobromophtholein and other tests; coagulotion tests: increase in prothrombin, Foctors VII, VIII, IX ond X; thyroid function: increase in PBI and butonal extractable protein bound iodine, ond decrease in T^3 uptake values; metyrapone test; pregnanediol determinotion.



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Psychiatric Treatment Methods — Veterans Administration Hospital, Brecksville; three hours a day, one day a month, October 8 through May 13, 1970; for specialists and nonspecialists.

Symposium on Renal Diseases — Trumbull Memorial Hospital, Warren; one day a month, September 23 through May 27, 1970; for specialists and nonspecialists.

Water and Electrolytes — Northwestern Ohio Institute for Continuing Medical Education and Medical College of Ohio at Toledo; at 3101 Collingwood Blvd., Toledo; two hours a day once a week, January 13 to March 10, 1970; for specialists and nonspecialists.

Visiting Professor Series (General Medicine) —Youngstown Hospital Association, Youngstown; two hours, one day a month; present through June, 1970; for specialists and nonspecialists.

Visiting Medical Faculty Weekly Seminars — Mercy Hospital, Springfield; 1½ hours, one day a week through May 30, 1970; for specialists and nonspecialists.

Basic Science Related to Obstetrics and Gynecology — St. Ann Hospital, Cleveland; one day a week, September 10 through January 28, 1970; for specialists and nonspecialists.

Electrocardiography Review — Youngstown Hospital Association; 1½ hours a day, two days a month; through June, 1970; for specialists.

Visiting Professor in Medicine — Youngstown Hospital Association; four hours a day one day a month, through June, 1970; for general practitioners.

Tumor Conference — Youngstown Hospital Association; two hours a day, once a week, through June, 1970; for specialists and nonspecialists.

January, 1970

Electromyography VIII — Ohio State University College of Medicine; January 26-28, 1970; for specialists.

Selected Problems in General Surgery — Cleveland Clinic Educational Foundation; January 14-15, 1970; for specialists and nonspecialists.

Microbiology — at the Cleveland Clinic; sponsored by American Society of Clinical Pathologists; January 5-9, 1970; for specialists.

Radiology — Central Ohio Radiological Society Meeting, January 8; Speaker; Sadek Hilal, M.D.

January *(Contd.)*

Seminar on Lumphoma and Leukemia — St. Rita's Hospital, Lima, Thomas Stevenson, M.D.; January 20.

Clinical Pathology — University of Cincinnati Medical Center, January 9.

Two Days of Pediatric Review — Good Samaritan Hospital, Cincinnati, Hospital, January 21-22; University of Cincinnati College of Medicine.

Annual Urology X-Ray Seminar — Netherland Hilton Hotel, Cincinnati, January 22-24; University of Cincinnati College of Medicine.

Medical Seminars — Youngstown Hospital Association, South Unit; **The Electrophysiology of Arrhythmias,** January 12; **Fungal Infections of the Skin,** January 26.

Cardiac Manifestations of Collagen Disease – Royston C. Lewis, M.D., Cleveland, speaker; Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, January 13, 8:15 p.m.

Seminar on Renal Failure—Veterans Administration Center, 4100 W. Third Street, Dayton; 10 a.m. to 3 p.m., January 28; Dr. Charles D. Swartz, head of Section of Nephrology and Vascular Diseases, Hahnemann Medical College, Philadelphia, visiting professor; contact H. Mehbod, M.D., at the center.

February, 1970

Three Days of Cardiology—Modern Cardiac Diagnosis — University of Cincinnati Medical Center, February 2-4.

General Practice — Cleveland Clinic Educational Foundation, February 4-5.

Annual Hospital Infection Control Symposium — University of Cincinnati Medical Center, February.

Selected Topics in Basic and Clinical Immunology — Cleveland Clinic Educational Foundation, February 25-26.

Practical Management of Ear, Nose, and Throat Disorders—Ohio State University College of Medicine, Columbus, February 19; for specialists and nonspecialists.

Second Annual Seminar on Advances in Clinical Pathology—University of Cincinnati College of Medicine, CONMED, at 104 Medical College Building, Eden and Bethesda Avenues, Cincinnati; February 17; for specialists and nonspecialists.

Medical Seminars—Youngstown Hospital Association, South Unit; **Stroke Syndrome and Localization of Lesions,** February 9; **The Hemostatic Process,** February 23.

Orthopedic Problems — Ohio State University College of Medicine, Columbus, February 25; for specialists and nonspecialists.

Gastroenterology—Inflammatory Bowel Diseases—Ohio State University College of Medicine, Columbus, for specialists and nonspecialists, February 18.

Intimacy in Psychotherapy, Religion and Medicine—Richard L. Baumgartner, M.D., Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, February 10, 8:15 p.m.; members of the clergy invited.

March, 1970

23rd Annual Medical Symposium—Lorain County Medical Society, 428 West Avenue, Elyria; symposium at Oberlin Inn, Oberlin, March 11.



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March *(Contd.)*

Pediatric Clinic Day—Ohio State University College of Medicine, Columbus, March 11; for specialists.

Current Management of Common Orthopedic Problems—Cleveland Clinic Educational Foundation, March 11-12; for specialists and nonspecialists.

Review Day in General Medicine—Ohio State University College of Medicine, Columbus, March 18.

Annual Cancer Symposium—Akron City Hospital, 525 E. Market Street, Akron, March 18-19; for specialists and nonspecialists.

Practical Management of Infectious Diseases, 1970—Ohio State University College of Medicine; for specialists and nonspecialists; March 25.

Multiple Sclerosis and Related Demyelinating Diseases—Ohio State University College of Medicine, Columbus, March 26; for specialists and nonspecialists.

Unwanted Pregnancy—a Preventable Pregnancy—Donald L. Hutchinson, M.D., Pittsburgh, Pa.; Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, March 10, 8:15 p.m.; wives and guests invited.

Medical Progress and Its Relationship to Dentistry—The Cleveland Clinic Educational Foundation, March 25-26.

Medical Seminars—Youngstown Hospital Association, South Unit; **Subacute Hepatitis**, March 9; **Lipoprotein Abnormalities and Coronary Atherosclerosis**, March 23.

April, 1970

New Directions in Coronary Care for the 1970's—American College of Cardiology, at Good Samaritan Hospital, 1425 W. Fairview Ave., Dayton, April 8-9.

Third Annual Cancer Symposium—Ohio State University College of Medicine, Columbus, April 1; for specialists and nonspecialists.

Postgraduate Course in Pathology—Cleveland Clinic Educational Foundation, 2020 E. 93rd Street, April 22-23; for specialists and nonspecialists.

Athletic Injuries—Marvin McClellan, M.D., Cincinnati; Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, April 14, 8:15 p.m.

Advances in Infectious Disease—Cleveland Clinic Educational Foundation, April 1-2.

Sports Medicine—Cleveland Clinic Educational Foundation, April 6-7.

Annual Laboratory Animal Medicine Conference—University of Cincinnati College of Medicine, April 25 at Christ Hospital, Cincinnati.

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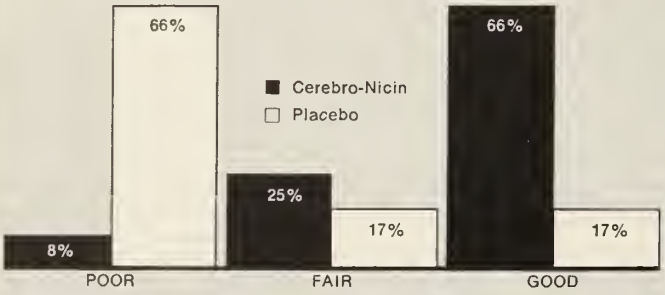
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Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

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Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 *strengths*

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.

Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.

Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.

Available:
Bottles of 60, 500.

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

***Dose:* 2 tablets daily.**
***Available:* Bottles of 60, 500.**

Write for literature and samples:

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REFER TO PDR

also available with ESTROGEN

Android—E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. DOSE: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRAINDICATIONS: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

A MESSAGE FROM

Your OSMA President

WITH THE JANUARY, 1970 issue, *The Ohio State Medical Journal* comes to you under a new cover and dressed in a new format. It is not a new Journal, but the beginning of Volume 66 of a publication that has faithfully served the medical profession of Ohio for nearly 65 years.

The Journal is published "by and for members of the Ohio State Medical Association," as its masthead proclaims. It is a "family publication" for the doctors of Ohio. It speaks for the medical profession of Ohio as no other publication can.

We are proud to have as Editor of *The Journal* Perry R. Ayres, M.D., a professional man who stands tall among his colleagues in practice and in medical education. The Editor has maintained an excellent balance in his selection of clinical and scientific articles. Among professional papers presented, one may find a county seat practitioner's observations on his farmer-patients, and in the same issue an elaborate report from one of our fine medical centers on a major research project.

A Broader Concept

In the future, non-clinical features of *The Journal* will appear under "Professional Activities." This is a broad category, as it is intended to be. The busy doctor spends much of his time in his office, in the hospital, and at the bedside of his patients. But he may also find time to talk to the Lions Club, spend a Friday evening on the bench with the local high school team, or participate in a measles innoculation drive. He'll find time to attend his County Medical Society meeting, hospital staff sessions, a specialty program or two, and he may even take an occasional look at the stockmarket page.

The Professional Activities reports will aim at the high spots of these and many other events and happenings in which the doctor is interested. Already *The Journal* has launched into some new, and we trust interesting, features. One of these is "Investment Prognosis"—observations on the investment markets especially written for doctors. Another is ". . . and We Quote," a column containing interesting excerpts from other publications. Some three pages in recent issues of *The Journal* have been devoted to listings of Continuing Medical Education Courses for Doctors of Ohio. Our State is fortunate in having so many excellent short courses available within easy reach of every doctor in the area. Ohio doctors in increasing numbers, we are sure, will want to take advantage of these excellent programs.

Seeking Top Talent

The Journal also has been printing more non-scientific by-line articles—excellent contributions by persons of talent in medicine and in related fields. These articles bring, through *The Journal* pages, some of the best thinking of our day as it relates to medicine and medicine's problems. In the future, *The Journal* will introduce articles with more divergence of opinion—controversial issues, if you wish.

Recently *The Journal* has been publishing more "Letters to the Editor," and will continue to do so when constructive comments come from its readers.

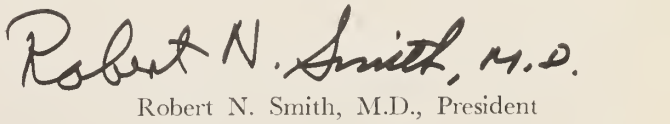
The Ohio State Medical Journal is the Number One medium of communications within the medical family of Ohio, known as the Ohio State Medical Association. Obviously, emphasis is on the physician-patient relationship, but every Doctor of Medicine in Ohio is involved, directly or indirectly, with patients, whether he is a family practitioner, a medical educator, a research specialist, or a health officer.

A Wider Scope

The Journal has made every effort to keep members informed and to stimulate their interests in the vital things of medicine and health. But information and stimulation are not enough in an age plagued by tension, permeated with emotion, and hesitant about any future commitments.

Obviously, *The Journal* will continue to inform and to stimulate, but it also will strive to reflect the medicine's moods, in the highest sense of that term. As the practitioner deals with "The whole patient," *The Journal* will attempt to reflect "the whole medical profession of Ohio."

It's your *Journal,* Doctor. Read it, and, if you find constructive criticism in order, the communication lines are open both ways.



Robert N. Smith, M.D., President
The Ohio State Medical Association

Made Your New Year's Resolutions?

Make Another—Make Plans Now to Attend the 1970 OSMA Annual Meeting—May 11-15 in Columbus

RESOLVE NOW to take time from your busy schedule. Take advantage of this once-a-year opportunity and join your colleagues for a "learn in" on the latest scientific aspects of professional medicine. The program is varied and there is something of interest for everyone. Theme for the 1970 OSMA Annual Meeting is "Together We Care."

The Sheraton-Columbus Hotel will again be headquarters, and the Veterans Memorial Building the site for exhibits and scientific meetings. For your convenience, the headquarters office is preregistering persons for the meeting. A preregistration form is in this issue of *The Journal;* fill it out, clip, and mail to the OSMA office now. Also in this issue is a hotel reservation form to be filled out and sent to the hotel of your choice. Don't be disappointed in hotel accommodations; make reservations now!!

More detailed information on highlights of the meeting are forthcoming in future issues of *The Journal.* Look for the entire program, with topics, names of speakers, and other details, to reach members of the Association through the mails prior to the Annual Meeting.

The following preview is published for the convenience of members and to acquaint readers with the format of the program.

Monday Afternoon, May 11

District Caucuses to be held by each respective district Councilor. Rooms will be assigned and announced for their use.

Monday Evening, May 11

House of Delegates registration followed by a buffet dinner.

First Session of the OSMA House of Delegates beginning at 7:00 P.M.

Tuesday Morning, May 12

Registration of Exhibitors

General and Preregistration

Conference sponsored by the Joint Advisory Committee on Athletic Injuries entitled "The Health Team—For Better Athletics, Better Living"

Meetings of House of Delegates Reference Committees.

Ohio Health Commissioners Institute.

Tuesday Noon, May 12

12:00 NOON All Exhibits Open.

12:00 NOON Orientation Session of new OSMA Members.

Tuesday Afternoon, May 12

Section on Pathology and Ohio Society of Pathologists

Continuation of meetings of House of Delegates Reference Committees.

OSMA General Session—NICK DALLIS, M.D.

School Health Conference entitled "Growing Up With Sex Education" sponsored by the Committee on School Health.

Ohio Health Commissioners Institute

Tuesday Evening, May 12

Council dinner honoring OSMA Past Presidents.

Ohio Health Commissioners Banquet.

Wednesday Morning, May 13

General Session—Program for Twelfth Annual Ohio Cancer Conference, sponsored by the Ohio Division, American Cancer Society.

Ohio Chapter, American College of Chest Physicians.

Section on Ear, Nose and Throat and the Ohio Society of Ear, Nose and Throat.

Executive Meeting of the Ohio Chapter, American Academy of Pediatrics.

Annual Business Meeting of the Ohio Ophthalmological Society.

Ohio Health Commissioners Institute.

Wednesday Noon, May 13

Ohio Medical Political Action Committee Luncheon.

Ohio Chapter, American Academy of Pediatrics Luncheon.

Continued on Next Page

Wednesday Noon *(Contd.)*

Section on Ear, Nose and Throat and the Ohio Society of Ear, Nose and Throat Luncheon.

Ohio State Society of Thoracic Surgeons Business Meeting and Luncheon.

Ohio Ophthalmological Society Luncheon.

Wednesday Afternoon, May 13

OSMA General Session—Roger Egeberg, M.D. (Tentative)

Section on Anesthesiology.

Section on Colon & Rectal Diseases.

Section on Ear, Nose and Throat and the Ohio Society of Ear, Nose and Throat.

Section on Internal Medicine.

Section on Ophthalmology and the Ohio Ophthalmological Society.

Section on Pediatrics and the Ohio Chapter, American Academy of Pediatrics.

Section on Obstetrics and Gynecology

Section on Rheumatology

Ohio Health Commissioners Institute.

Wednesday Evening, May 13

Western Reserve—Cocktail Party.

OSMA Social Function—"Far East Fling"

Thursday Morning, May 14

Breakfast Meeting, Ohio Committee on Trauma, American College of Surgeons.

General Session—Program sponsored by the Ohio State Heart Association.

Ohio Health Commissioners Institute.

Section on Occupational Medicine.

Executive Committee Meeting, Ohio Committee on Trauma, American College of Surgeons.

General Session—Sponsored by SAMA Chapters.

12:00 NOON—Complimentary Luncheon for Exhibitors.

Thursday Afternoon, May 14

Business Meeting of the Section on Plastic Surgery.

General Session—Sponsored by the Section on Plastic Surgery.

OSMA General Session—Dr. Norman Vincent Peale.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 11-15.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 12.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 1 (a), entitled "Nomination of President-Elect."

Thursday Afternoon *(Contd.)*

General Session—Program sponsored by the Ohio Committee on Trauma, American College of Surgeons.

Combined Section programs of the Directors of Medical Education and General Practice.

Section on Neurological Surgery and the Ohio Neurosurgical Society.

Section on Physical Medicine and Rehabilitation.

Thursday Evening, May 14

Dinner meeting of Physical Medicine and Rehabilitation.

Buffet Dinner for members of the OSMA House of Delegates, Alternates and Official Guests.

Registration—Final Session of the OSMA House of Delegates.

Final Business Session of the OSMA House of Delegates.

OSMA Council Meeting.

Friday Morning, May 15

Meeting of the OSMA Delegates and Alternates to the American Medical Association.

Remember: REGISTER NOW... AVOID LONG LINES SAVE TIME...



Remember the convenience of pre-registration last year? No long lines, no fumbling for your credentials, everything for the meeting in one envelope. It did save time, didn't it? It was so successful that we will be offering this service again this year. In case you have forgotten the procedure, HERE IS HOW IT WORKS – after OSMA receives your PRE-REGISTRATION FORM we will check membership and fill out your registration card. We will then make a badge for you and your wife if you have indicated that she will be attending, place your badge, program and requested social function tickets and luncheon tickets in an envelope in your name. Then all you need to do is come to the PRE-REGISTRATION DESK and ask for your envelope in your name and you are ready to visit the exhibits and attend the meetings of your choice. Make ONE STOP do it, you will be glad you did!!!

Fill It Out

PRE-REGISTRATION FORM

1970 Annual Meeting
Columbus, Ohio

Ohio State Medical Association
May 11 - 15, 1970

Name _____
(Please Print)

Address _____
(Number and Street) (City) (State)

I am:

- ☐ OSMA Member
- ☐ Official OSMA Delegate
- ☐ Official OSMA Alternate
- ☐ Non-member Physician
- ☐ Guest
- ☐ Medical Student
- ☐ Scientific Exhibitor
- ☐ Executive Secretary
- ☐ News Media

Please prepare guest badge for my spouse.

_____
(Please Print Name)

– SOCIAL FUNCTION TICKETS –
RESERVATIONS

Note: (No tickets reserved without money)

Make checks payable to:
Ohio State Medical Association

Mail this form to:
Ohio State Medical Association
17 South High Street, Suite 500
Columbus, Ohio 43215

Wednesday, May 13, 1970 – 11:30 A.M.
"OMPAC Luncheon" Number
Sheraton-Columbus Hotel
$5.00 per person . . . . . .

Wednesday, May 13, 1970 – 7:00 P.M.
"Far East Fling"
Sheraton-Columbus Hotel
$12.00 per person . . . . . .

Thursday, May 14, 1970 – 12:00 Noon
"Exhibitors Luncheon"
Veterans Memorial Building
$4.00 per person . . . . . .
(Complimentary to Exhibitors)

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Columbus May 11 - 15

Leading Downtown Columbus Hotels at Prevailing Rates

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Singles	$15.00 - $20.00
Doubles	$20.00 - $25.00
Twins	$20.00 - $25.00

Neil House Motor Hotel
41 Sauth High Street

Singles	$11.00 - $19.00
Doubles	$14.00 - $18.00
Twins	$15.00 - $23.00

Southern Hotel
Sauth High and East Main Streets

Singles	$10.00 - $15.00
Doubles	$13.50 - $15.00
Twins	$14.00 - $17.00

Holiday Inn-Downtown
175 East Tawn Street

Singles	$13.50
Daubles	$18.50
Twins	$18.50

Christopher Inn
300 East Braad St.
(Woman's Auxiliary Headquarters)

Singles	$13.50 - $15.00
Doubles	$18.00
Twins	$20.00

Pick-Fort Hayes Hotel
31 West Spring Street

Singles	$12.00 - $17.00
Daubles	$16.00 - $20.00
Twins	$16.00 - $20.00

All rates subject to change.

If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____Columbus, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 11 - 15 (or for period indicated).

_____Single Room _____Twin Room

_____Double Room Other Accommodations _____

Price Range_____

Arrival: May_____at _____A.M. _____P.M.

Departure: May_____at _____A.M. _____P.M.

PLEASE VERIFY MY RESERVATION

Name_____

Address_____

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By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

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Activities of County Societies...

BELMONT

The Belmont County Medical Society with the Auxiliary met at the Belmont Hills Country Club on November 20 for dinner and a program. Speaker for the scientific part of the program was Dr. Chester Winter, Columbus urologist and associated with Ohio State University College of Medicine, whose subject was "Urinary Infections in Children."

CUYAHOGA

The thirty-second annual Lower Lecture was presented at the Academy of Medicine of Cleveland auditorium on November 19. Subject for the occasion was "Medical Knowledge Gained in Apollo Manned Spaceflights," the speaker being Dr. Charles A. Berry, director of medical research and operations, National Aeronautics and Space Administration Manned Spacecraft Center, Houston, Texas.

FRANKLIN

Jesse Owens, former Ohioan and Olympic track star, was guest speaker for the November 18 meeting of the Academy of Medicine of Columbus and Franklin County. His topic was "Athletics in Everyday Living." Jesse Owens attended high school in Cleveland and college at Ohio State University where he established numerous new track records. He gained world fame at the 1936 Olympic games in Berlin. Now residing in Chicago, he participates in numerous community programs relating to children and youth.

A social hour and dinner preceded the meeting at the Imperial House North in Columbus.

Butler County Physician Honored



Mildred Law Snyder, M.D., Middletown physician, recently was honored by the Ohio State Medical Association and the Butler County Medical Society, and was presented a plaque to commemorate her 50th year and her devotion to service in the medical profession. Pictured with Dr. Snyder are, left, Paul N. Ivins, M.D., First District Councilor, and John H. Varney, M.D., President of the Butler County Medical Society.

HAMILTON

Nine physicians were honored for 50 years of outstanding service in the medical profession at the November meeting of the Academy of Medicine of Cincinnati.

Certificates commending them for long and outstanding service in the medical profession were issued by the Ohio State Medical Association and presented to them along with 50-Year service buttons.

Those honored are Drs. Burr Noland Carter, Oleen K. E. Kitsmiller, Verle R. Kitsmiller, Davis Lillard, Donald J. Lyle, Charles S. Noonan, Schuyler C. Rousey, George F. Patterson, and John H. Skavlem.

MONTGOMERY

The annual "Membership Meeting" of the Montgomery County Medical Society was held on November 13 at the Statler-Hilton Hotel where a social hour and dinner preceded the program.

Guest speaker for the occasion was Dr. Gordon Stewart, professor and chairman of the Department of Epidemiology at Tulane University, New Orleans, whose topic was "Infectious Diseases."

OMPAC Does What Medical Societies Can't Do; Give It Your Support

It is time that the apparent confusion which exists in the minds of far too many Ohio physicians with regard to the fundamental difference between medical societies and medical political action organizations should be dispelled.

Medical societies—American Medical Association, Ohio State Medical Association and local academy of medicine or county medical society—play an active role in representing the medical profession in preparation of legislation for the Congress and the Ohio State Legislature; in presenting arguments pro or con on various medical-health issues; in working with the executive branches of the national and state governments which administer the laws enacted; and keeping Ohio physicians properly informed on what's going on in Washington and Columbus.

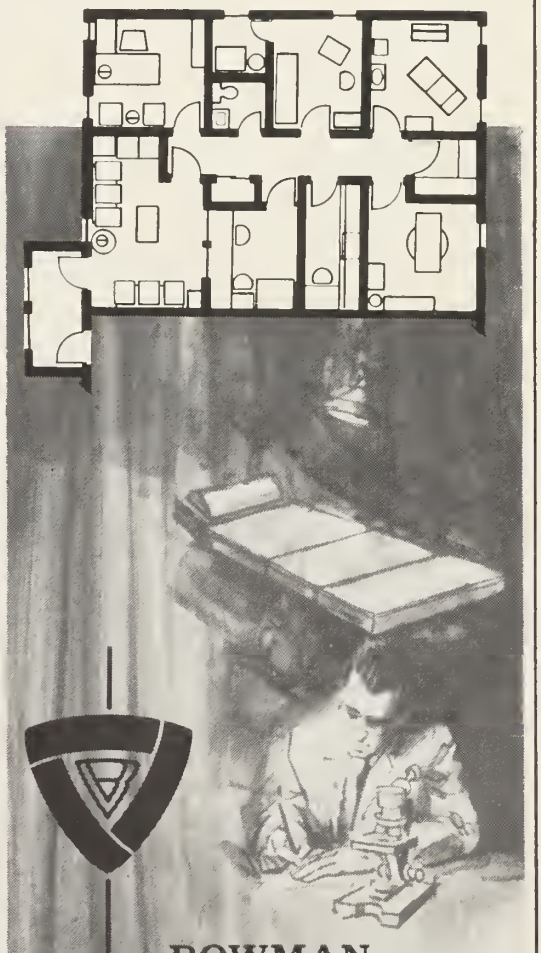
On the other hand, the American Medical Political Action Committee and the Ohio Medical Political Action Committee were organized to finance and sponsor those activities which the medical societies are prohibited by law from undertaking. Specifically, they operate in the political fields, endorsing candidates and providing acceptable ones with financial assistance. AMPAC and OMPAC raise their funds from individual physicians. Obviously, there is an exchange of information and suggestions between the medical societies and the medical political organizations, but they do not compete in any sense of the word—actually complementing each other.

For more complete information on the purposes and activities of the Ohio Medical Political Action Committee, physicians should study a series of brief flyers prepared by OMPAC and being mailed with the OSMAgram. These tell the story of why OMPAC is the "strong right arm" of the medical profession of Ohio; they outline the fine records made by OMPAC in the 1966 and 1968 elections; and tell why payment of OMPAC dues at the same time medical societies dues are paid is of vital importance.

Dr. Benjamin B. Caplan, Columbus, recently headed a special humanitarian project through which Bolivian children were immunized with polio vaccine.

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Ohio Resident Awarded Pfizer Medical Scholarship

Kenneth R. Hofstetter, Dalton, Ohio, has been awarded a $1,000 scholarship for the 1969-1970 school year by the Ohio State University Medical School.

A graduate of Goshen College in 1966, Mr. Hofstetter is a member of the class of 1970 at Ohio State University Medical School. He was awarded the scholarship by school authorities on the basis of academic qualifications. Mr. Hofstetter is married.

The scholarship was made available by the Pfizer Laboratories Division, which markets a wide range of ethical pharmaceutical products. A similar scholarship provided by the division is also available at all 99 medical schools in the United States.

Physician at OSU Named Vice-Provost for Curricula

Lloyd R. Evans, M.D., former associate dean and secretary, Ohio State University College of Medicine, was appointed in the fall as the University's vice-provost for curricula. He is serving in the office of the University's new vice-president and provost, James A. Robinson, Ph.D., and is continuing in his appointment as professor of medicine.

Henry Cramblett, M.D., chairman of the Department of Medical Microbiology, has been named secretary of the College of Medicine.

Dr. Richard D. Bryant, Cincinnati, was the subject of a feature article in the Cincinnati *Post & Times Star*. The article reported a reception given for Dr. Bryant following his retirement from active practice and attended by members of some 650 families representing his former patients.

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Investment Prognosis

By Frank Van Holte, Columbus

IT IS VERY DIFFICULT to be a "sound seer" at the present time. Prospects are discouraging for near-term progress on the Vietnam problem. Corporate profits are under pressure principally due to the declining utilization of capacity, fiscal and credit restraints and high labor costs. The slow-up of sales of new cars is not a good augury or portent. It seems to me that this cooling of the U. S. economy makes it apparent that we must soon have some modifications in U. S. credit policy.

Although it will probably be a long time before we will see the preinflation 5½ percent mortgage, any reasonable easing of interest rates will obviously increase the flow of mortgage money and this easing is extremely important in the solution of the housing problem. The growth in the number of households in the U. S. require that we build 2 million new units each year. In the past few years, we have been building only 1,300,000 units and this annual deficit of units is compounding the problem. It is easy to understand the boom in the production of mobile homes. The eventual surge in housing construction offers an attractive opportunity for investments in companies which will benefit from this boom, as I mentioned in my last investment article.

Frequently we hear that bonds are not a good investment because they provide a fixed income and they do not offer the opportunity for appreciation in value such as we find in common stocks. But, the validity of this opinion or statement is certainly being tested today. Bond yields are at an all-time high today but it is not reasonable to assume that these yields will remain at these high levels. And when the yields decline, the bond prices will rise. By way of illustration, should recently issued, 30 year bonds yielding 8½ percent, drop to a yield of 7 percent within a year, we can expect the price to rise about 18½ percent. If this would occur, we would see a bond with a total income of over 27 percent (8½ percent income plus 18½ percent appreciation). This possibly explains why more and more individuals are buying bonds today. A guaranteed income of 8½ percent plus the good possibility of appreciation is certainly attractive.

Mutual Funds usually provide an annual capital gain's distribution. If you have an investment in mutual funds, I believe that your best interests will be served if you elect to accept this distribution in additional shares of stock rather than a cash payment. If you accept cash, a portion of your capital is taken out of the fund, and thus you will have less capital invested on which to earn dividends. If you take the distribution in stock in lieu of cash, you will maintain your investment in the fund.

Incidentally, mutual funds are an attractive investment if you do not have the **time,** training or temperament to handle your own investments. They provide the way to buy a stake in the **long-term** growth of our economy. The current market decline affords an opportunity to buy into the mutual fund or funds of your choice at today's low prices.

Many investors fall prey to tips and rumors and ignore completely any professional advice in the investment of their funds. Certainly, I would advise you to test your investment selections against the opinion of your experienced broker. It seems to me that the medical profession should be especially aware of the necessity of seeking a consultation from a qualified source.

A decline in security prices always causes concern to investors, but also creates opportunities for the alert investor. The astute investor buys when most people are bearish and sells when most people are bullish. Of course, it is difficult to commit yourself in the market. When we decide to sell, we postpone our action because we believe tomorrow's prices will be higher. When we decide to buy, we postpone our action because we look for a lower price tomorrow. Ideally, when a stock is historically low in price and is otherwise attractive, we should buy it and not try to find the bottom of the market. There are some bargains in the market today and they represent excellent buys regardless of what the price will be tomorrow.

This monthly feature is written exclusively for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Eight Pressing Health Problems...

Your AMA Leads the Way and Urges Physicians and Medical Societies to Join in Seeking Solutions

PRIORITY OBJECTIVES in the vast activities and operations of the American Medical Association include seeking solutions to what have been defined as eight of the most pressing health problems now confronting the nation. In pinpointing these problems, Dr. Burtis E. Montgomery, chairman of the AMA Board of Trustees, urged physicians and medical societies to join the AMA in seeking satisfactory solutions to them. He quoted the following Chinese proverb as an appropriate long-range view of the situation: "We plant trees today so that others may have shade tomorrow."

Following is a listing of the eight most pressing health problems as identified by the AMA with brief comments on what has been done and is being done to alleviate them.

The Acute Shortage of Health Manpower: The demand for health care has created an imbalance in the supply-demand equation of health professionals and other personnel. Increasing affluence, longer life, greater appreciation of good health care, and such government programs as Medicare and Medicaid have greatly increased the demand. Consequently, the AMA, in cooperation with the Association of American Medical Colleges, is urging all medical schools to expand their enrollments and offers its assistance in establishing new schools. Success of this approach to date is evidenced by 24 new medical schools created since World War II, raising to 101 the total of schools now accepting students. Others are in the planning or construction stage, and most existing schools have increased their enrollment.

The AMA Council on Medical Education is cooperating with attempts of medical schools to reduce the length of medical training and is reviewing the time required by various specialty boards for certification of specialists.

The AMA Committee on Education for Related Health Professions and the AMA Council on Health Manpower also are stimulating a variety of programs to develop new physicians' assistants, new health care roles for nurses, and innovative steps to increase total productivity. The Association has adopted essentials of accredited educational courses and accredits programs for 13 different technologists. In addition, it endorses increased federal approriations for both the schools and individual students.

Rising Health Care Costs: The AMA is working closely with the American Hospital Association and hospital medical staffs to review every item of hospital costs in an effort to remove those items which should be supported by other means. Physicians also are being encouraged to eliminate hospital care or reduce it whenever possible and to use less expensive extended care facilities and home health care services. The AMA is now preparing a public education program to illustrate how unrealistic demands for health care inflate costs.

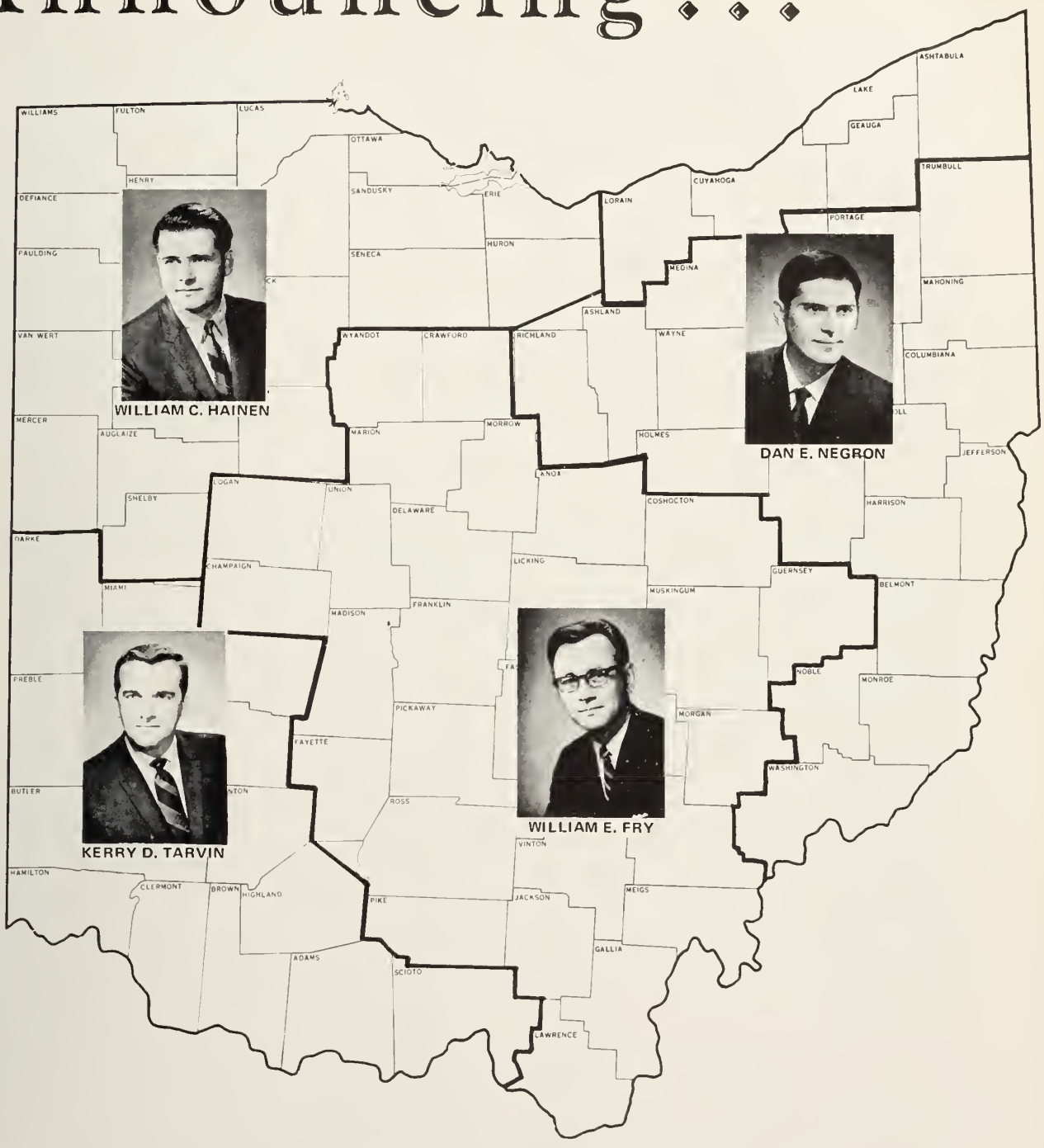
Financing Health Care: The AMA supports a national health insurance plan based on tax credits and certificates that would enable all Americans to purchase comprehensive health insurance coverage. Its proposal would establish a sliding scale of tax credits depending on the individual's tax liability, and the credits would be applied to health insurance provided by private carriers.

Mental Health: The AMA proposed the program that was enacted by Congress to establish a network of nationwide community mental health centers. The program involves close cooperation with the mental health administration and other experts to discover more efficient methods of treatment and rehabilitation, allowing a quicker return to productive work by the patients.

Pollution: The AMA Council on Environmental and Public Health has held several national conferences on the problem of pollution of the air, waterways and the land, and it is working closely with governmental and private agencies to ameliorate this growing health hazard.

Alcoholism and Drug Addiction: The widespread use of alcohol has been accompanied by millions of medically identifiable alcoholics. They suffer a type of drug addiction which requires medical therapy and which is the cause of 50 percent of all fatal accidents and innumerable criminal acts. Consequently, the AMA Commit-

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tee on Alcoholism and Drug Dependence continues to conduct a major educational program in this area, directed at both adults and youths.

Health Care of Slum Residents: The AMA Committee on Health Care of the Poor, recognizing that the problem of health care in the slum is basically a problem of the slum itself, is conducting a series of studies and conferences with civic and social leaders, and it is preparing specific recommendations to improve both the quality and delivery of health care in these areas.

Malnutrition: Poor nutrition is more far-reaching than most people suspect. It covers not only the underprivileged, but also the middle-income group and relates strongly to education at all levels of society. The AMA has adopted an aggressive program to fight hunger and malnutrition; local societies are being encouraged to meet with community dietitians, dentists and other health specialists in resource seminars and to participate in area health surveys.

In addition, the AMA will publicize guidelines for the evaluation of malnutrition, examine the science of nutrition as part of formal medical education, seek development of a central coordinating agency for nutrition at a high level in the executive branch of government, urge development of urban and rural programs to provide health services with a nutritional emphasis, and evaluate current nutritional education in schools.

Doctor Montgomery, speaking in behalf of the AMA Board of Trustees, has asked each medical society to help implement these programs at both the state and local level. "Everything physicians do today to help find solutions to these eight major health problems will affect, in large or small part, what physicians of tomorrow will be able to accomplish," he said.

Resolution of Ohio Colleges Thanks Legislative Consultant

A copy of the following resolution bearing the signatures of H. L. Yochum, president of the Association of Independent Colleges and Universities of Ohio, and R. W. Shoemaker, executive director, was forwarded to *The Journal.*

"RESOLVED, That the officers, directors, and members of the Association of Independent Colleges and Universities of Ohio at the organization's first annual meeting express their deepest appreciation for the services as Consultant of George H. ("Scottie") Saville. As recommended by the Executive Committee on January 3, 1969, and authorized by the Board of Directors on the same date, Mr. Saville served as Consultant through the regular 1969 session of the 108th Ohio General Assembly. He was instrumental in securing enactment of an Instructional Grant Program to benefit young people of Ohio attending both private and public colleges and universities within the State, as included in Am. Sub. HB 531. The establishment of the Instructional Grant program got the newly formed AICUO off to an auspicious start.

"Working closely with the Executive Director of the Association, Mr. Saville was most effective in his dealings with the Legislators. He was the very model of deftness combined with firmness and persistence, overcoming all obstacles placed in his path by lack of interest or even resistance.

"We thank Mr. Saville most heartily for his excellent service to the Association, to Ohio's privately supported colleges and universities, and to higher education in its entirety."

(Editor's Note: Mr. Saville, as his many friends in the medical profession know, retired in 1965 as Executive Secretary of the Ohio State Medical Association.)

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You might also say that all otolaryngologists aren't alike, either.







Exhibits Wanted

1970 Annual Meeting
Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association is just the place to display it. We are now accepting applications for the 1970 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be May 12, 13 and 14.

APPLICATION FOR SPACE SCIENTIFIC EXHIBITS

1970 Annual Meeting, Ohio State Meeting Association

Veterans Memorial Building, Columbus, Ohio, May 11-15

1. Title of Exhibit:_____

2. Name(s) of Exhibitor(s):_____

   Institution (if desired):_____

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3. Do you have a built-in exhibit?_____

4. Description of Exhibit: (Attach 200 word description to this blank)_____

Deadline For Filing Applications, January 30, 1970

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The American Board of Family Practice announces that it will give its FIRST examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 28-March 1, 1970.

Information regarding the examination and eligibility for the examination can be obtained by writing: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center Annex #2, Room 229, Lexington, Kentucky 40506.

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Ad Astra

Samuel Braun, M.D., Cleveland; medical degree from the University of Budapest, Hungary, 1921; aged 81; died November 27; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; resident of the Cleveland area since 1924 and practitioner of long standing there; trustee of the Taylor Road Synagogue and vice-president of the Orthodox Congregation of America; survived by his widow, three sons, and two brothers.

James T. Collins, M.D., Cleveland; Western Reserve University School of Medicine, 1918; aged 79; died October 26; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; practitioner of long standing in Cleveland where he specialized in ophthalmology and otolaryngology; survived by a son and a daughter.

Edward H. Cushing, M.D., Washington, D.C., Harvard Medical School, 1923; aged 71; died November 15; diplomate of the American Board of Internal Medicine and member of a number of professional associations; native Ohioan and former practitioner in Cleveland; distinguished career in the Naval Medical Corps during World War II; later distinguished service record with the Veterans Administration and in government service; survived by his former wife and two daughters.

Frederick Joseph Ebstein, M.D., Columbus; medical degree from the University of Berlin, 1921; aged 76; died May 12; member of the Ohio State Medical Association, the American Medical Association, and the American Thoracic Society; Fellow of the American College of Chest Physicians; retired in recent years; for several years associated with the Benjamin Franklin Hospital in Columbus; former superintendent of the Licking County Tuberculosis Sanatorium in Newark; survived by his widow.

Mark Frederick Hance, M.D., Troy; University of Chicago School of Medicine, 1947; aged 46; died November 5; member of the Ohio State Medical Association and the American Medical Association; native of Troy and practitioner there since 1956, specializing in pediatrics; member of the Rotary Club and the Methodist Church; survived by his parents, Dr. and Mrs. G. J. Hance, also of Troy; a sister, and a brother, Dr. Joseph W. Hance, of Detroit.

Festus Augustus Johnson, M.D., Akron; Faculty of Medicine, McGill University, Montreal, Canada, 1917; aged 78; died September 7; member of the Ohio State Medical Association and the American Medical Association; retired in recent years; formerly practiced in Akron specializing in the eye, ear, nose and throat field; served in the Army Medical Corps during World War II; survived by his widow.

E. Edwin Rakestraw, M.D., Findlay; Ohio State University College of Medicine, 1922; aged 72; died November 6; member of the Ohio State Medical Association and the American Medical Association; past president of the Hancock County Medical Society; retired in recent years; devoted virtually all of his professional career to practice in the Findlay area; member of the Findlay board of education; former president of local Rotary Club; member Ohio Dairymen's Association; survived by his widow, a daughter, a son, and a sister.

Thomas Asbury Ratliff, M.D., Cincinnati; University of Pennsylvania School of Medicine, 1911; aged 83; died November 18; member of the Ohio State Medical Association, the American Medical Association, the American Psychoanalytic Association, American Psychiatric Association, and the Central Neuropsychiatric Association; diplomate of the American Board of Psychiatry and Neurology; native of Cincinnati and practitioner there for many years; later moved his practice to California and returned to Cincinnati in 1965 where he continued to practice; formerly on the faculty of the University of Cincinnati; member of the Rotary Club and several Masonic bodies.

William Thomas Repasky, M.D., Middletown; University of Cincinnati College of Medicine, 1959; aged 34; died October 27; member of the Ohio State Medical Association and the American Medical Association; former resident in medicine at Cincinnati General Hospital; estab-

lished his practice in Middletown in 1966; assistant clinical professor of medicine at University of Cincinnati; survived by his widow, two sons, a daughter, his mother, a sister, and two brothers.

Everett James Robertson, M.D., Milford, Delaware; Howard University College of Medicine, 1941; aged 60; died July 4; former member of the Ohio State Medical Association; formerly resided in Cleveland where he was engaged in general practice and dermatology.

Leopold Simon, M.D., Cincinnati; medical degree from the Justus-Liebig University, Giessen, Germany, 1920; aged 76; died September 4; member of the Ohio State Medical Association and the American Medical Association; formerly practiced in Europe and practitioner in this country from the early '40's. His practice was in the Wyoming and Lockland areas of Greater Cincinnati.

Henry Sisek, M.D., Youngstown; Western Reserve University School of Medicine, 1930; aged 65; died November 19; member of the Ohio State Medical Association and former member of the American Medical Association; practiced for some 30 years in Youngstown; served in the Army Medical Corps during World War II; former member of the board of the Jackson-Perkins Rose Gardens; member of the Elks Lodge; survived by his widow, two sons, two daughters, two brothers, and a stepbrother.

Charles Sidney Smith, M.D., Dayton; University of Michigan School of Medicine, 1912; aged 84; died October 27; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; physician and surgeon in the Dayton area for more than 50 years before his retirement in 1963; member of the Methodist Church; survived by his widow; two daughters, and a son.

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during November. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

ALLEN
- Kin-Yee Mak, Lima

CUYAHOGA
- William R. Bauer, Cleveland
- Sheldon A. Polster, Cleveland

HAMILTON
- Bernard S. Aron, Cincinnati
- Nicholas R. Baumgartner, Jr., Cincinnati
- Henry J. Heimlich, Cincinnati
- Joseph Sirkin, Cincinnati
- Walden R. Smith, Cincinnati

LORAIN
- Matthew B. Jagielski, Elyria

LUCAS
- Anthony M. Iannone, Toledo
- John Rogers Smith, Toledo

MONTGOMERY
- R. Alan Baker, Dayton
- Delores D. de Guzman, Dayton
- Alfred Hicks, II, Dayton
- Arthur L. Klein, Dayton
- Ronald L. McCartney, Dayton
- Donald M. Posner, Dayton
- James A. Thomas, Dayton
- James S. Ungerleider, Dayton
- John S. Wang, Dayton

SUMMIT
- Ramachandra Bavikatty, Akron

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Woman's Auxiliary Highlights...

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

OUR TRAVELING STATE PRESIDENT, Mrs. Samuel L. Meltzer, was in Cincinnati recently and asked me to remind auxilians about a couple of items. Then along came a memo from our communications chairman, Mrs. J. Paul Sauvageot, with the same information. If we can rely on our doctor-husbands to carry this column home, we'll all be up to date.

Self Defense Pointers

With crime increasing, interest grows in teaching women and girls how to protect themselves. The Central Office has mimeographed copies of "Self-defense for Women" and they're yours for the asking. The Central Office address is 4770 Indianola Avenue, Columbus 43214. Mrs. Lucille Egger, our secretary, is there three days a week, Tuesday, Wednesday, and Thursday.

Radio and Television Scripts

Auxiliaries wishing to promote health education through radio and television should write the Central Office for sample scripts or for the 13-week series. The ten-minute programs called "The Health Reporter" were written by Ruth Meltzer. Perhaps your local stations would like to sponsor the series for the auxiliary, especially where medical societies and/or Blue Cross do nothing of this sort.

Scioto County Auxiliary is currently presenting the series on radio station WPAY. Members participating include: Mrs. Louis R. Chaboudy, Mrs. Ralph Herms, Mrs. Robert Martin, Mrs. William Miller, Mrs. Jack McDonald, Mrs. Harlan Williams, Mrs. William Daehler, and Mrs. Meltzer.

Sustaining Memberships Needed

Gals who are wives of medical students and interns and residents are trying to increase the number of $5.00 sustaining memberships among auxiliary members. These enthusiastic young wives are putting lost of time, energy and talent into WA-SAMA and they can really stretch the proverbial dollar. If you are interested in helping them, please send a $5.00 check to Mrs. Floyd Beman, 310 East Torrence Road, Columbus 43214.

WA-SAMA and WA-AMA Cooperate

On the national level WA-SAMA officers offered to work with auxilians in recruiting for health manpower. They should be particularly effective in this endeavor because of their youth, their enthusiasm and their own close involvement. This is the first official participation of the two organizations in the country.

Word comes from Cincinnati about cooperation on the local level. The University chapter of WA-SAMA is an active and attractive group. Two of their current projects have received wholehearted support by the Hamilton County Auxiliary. To raise funds for their philanthropies, the young medical student wives are available as party assistants. The minimum fee for at least two girls is $15.00 per evening, with another $10.00

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Samuel L. Meltzer
2442 Dorman Drive
Portsmouth, 45662

President-Elect
Mrs. Carl F. Goll
1001 Granard Parkway
Steubenville, 43952

Past President
Mrs. Malachi W. Sloan II
415 Towerview Road
Dayton, 45429

First Vice-President
Mrs. Paul A. Jones
423 Coventry Circle
Zanesville, 43701

Second Vice-President
Mrs. Russell L. Wiessinger
2280 W. Wayne Street
Lima, 45805

Third Vice-President
Mrs. H. I. Humphrey
389 S. Drexel Avenue
Columbus, 43209

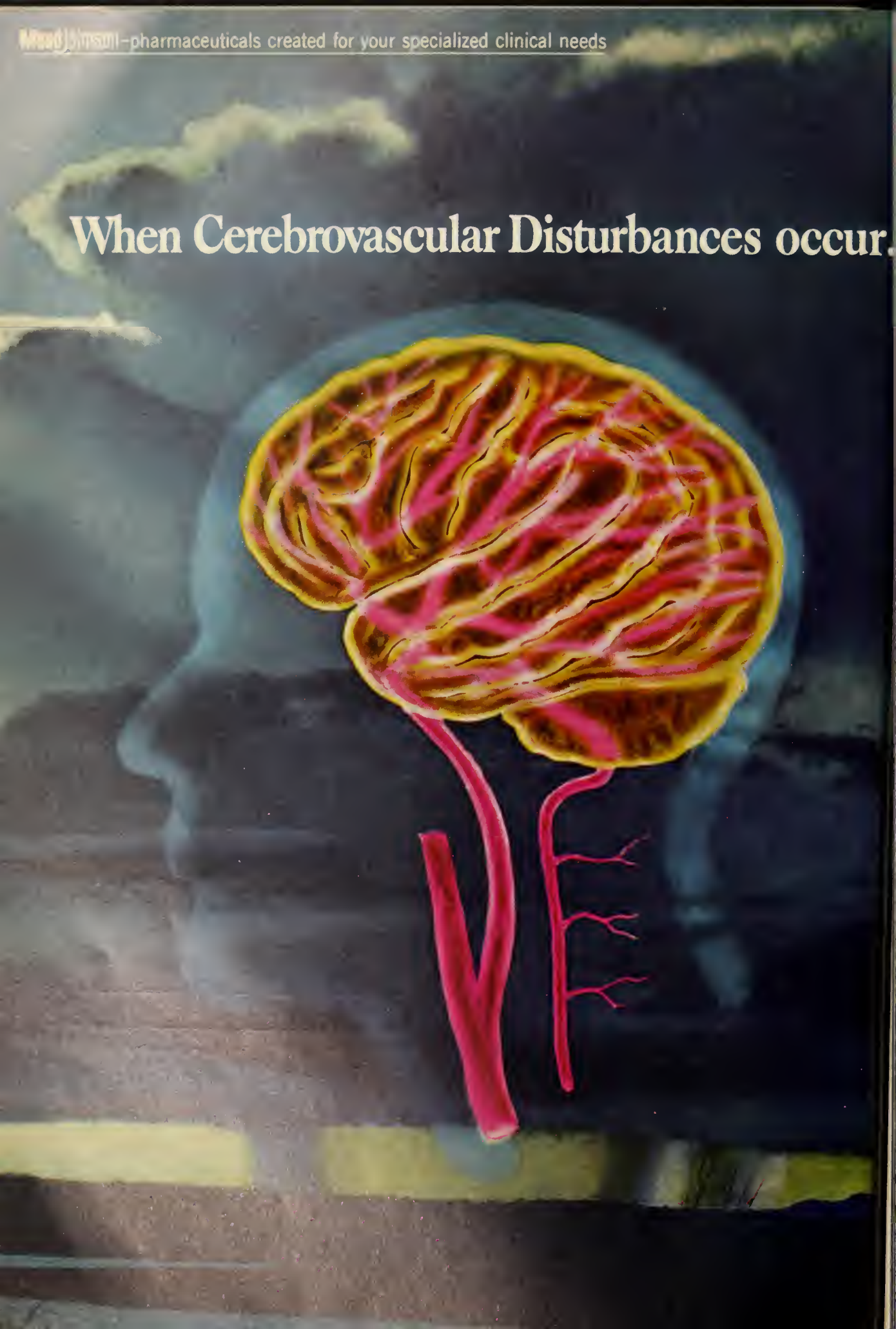
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for each additional girl. They arrive one-half hour before the guests to help with final details of preparation. They serve food and beverages during the party, then wash dishes and clean up afterwards.

To help their own personal budgets, WA-SAMA members are also available as baby sitters. This service is offered for extended vacations, weekends, by day or evening, and on a group basis for the regular monthly meetings of the auxiliary. This latter idea resulted from a luncheon meeting of Pat Leder, WA-SAMA president; Winnie Barrows, WA-SAMA advisor; and Lisa Foldes, auxiliary president. It was given a trial run at the Netherland Hilton Hotel in November. Can you imagine the convenience of dropping your little one at a central spot at 10 a.m., running an errand, attending the meeting, and then picking your youngster up at 3:30 p.m. just in time to return home — all for $1.00 and a sack lunch?

Drug Abuse Discussed

The Mahoning County Auxiliary met jointly with the Bar Auxiliary and guests from other professional auxiliaries in October. Panel members discussing drug abuse were Dr. C. Wattner, Superintendent of Woodside Receiving Hospital; Attorney J. R. Ryan, referee of Mahoning County Juvenile Court; and Mr. Orlando DiLullo of the Mahoning County Sheriff's Department. They presented a most realistic picture of the drugs being used by young people, the punishment meted out if the user is caught, and how young people are introduced to drugs. Auxilian, Mrs. Petraglia served as moderator for the panel.

Mrs. Taylor, chairman, arranged for Captain DiLullo and a past drug user to speak to seniors at Rayen High School. The program was well received and Mrs. Taylor's committee plans similar efforts in the future.

The Gourmet Way to Raise Funds

"Bird and Bottle" was the theme of the annual fund raising dinner held by Scioto County Auxiliary in November. Foods from a variety of countries were featured in the menu. Cocktails were served at the home of Dr. and Mrs. Robert Martin, and the dinner itself at the home of Dr. and Mrs. Harlen Williams.

Cuyahoga County Reports

The annual Chrysanthemum Ball of the Woman's Auxiliary to the Academy of Medicine of Cleveland was held on November 8. Among the many honored guests were Dr. Leo Walzer, president of the Academy of Medicine, and his wife; Mrs. Samuel L. Meltzer, state auxiliary president; Mrs. Carl Goll, state auxiliary president-elect, and her husband, Dr. Goll.

Mrs. Richard J. Nowak, this year's chairman, and her committee had a threefold objective for the ball: simplicity, congeniality and sociability. Large yellow felt chrysanthemums were used for table centerpieces. Proceeds were added to the Philanthropy Fund for AMA-ERF and other benefits. Committee members were: Mrs. William R. Young, Mrs. David J. Albert, Mrs. Chet R. Lulenski, Mrs. Michael A. Petti and Mrs. Norbert S. Gizinski.

Early in November, the Academy of Medicine of Cleveland sponsored a three-day seminar on drug use and abuse. Mrs. Kent L. Brown, president of the auxiliary, served as moderator for one of the sessions. The auxiliary furnished hostesses throughout the conference, ten were on duty at all times. As a follow-up to the seminar, the Auxiliary is having a one-day meeting on Friday, January 23 for lay persons.

December Calendars were Full

The Woman's Auxiliary to the Stark County Medical Society held a Christmas Tea at the home of Mrs. Fabio Rodriguez. Gifts were collected for needy youngsters in the community. Committee members were: Mrs. Sidney Larson, Mrs. Jack Yahraus, Mrs. V. Blumentals, Mrs. S. Centrone, Mrs. W. J. Howland, Mrs. J. D. Joliet, Mrs. J. F. McCutcheon and Mrs. B. Panasiuk.

In Cleveland auxilians held a Christmas party for foreign doctors' families (wives and children) at the Academy. Stockings for the children were prepared by Junior Girl Scout Troops in Berea.

The annual Holiday Ball of The Woman's Auxiliary to the Academy of Medicine of Cincinnati was held on December 6. The Apple Tree, day-care center for children of professional hospital employees, will benefit from this event. Mrs. George D. J. Griffin and Mrs. Robert E. Gregory served as cochairmen for the evening. Appropriately, apples were predominant in the decorations — little felt apples for name tags, bright red apples hanging from Christmas trees around the ballroom, and apples in the table centerpieces too!

Doctor, after all we've been through together...

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listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
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DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1970 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Monday evening, May 11, at the Columbus-Sheraton Hotel, Columbus.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must be filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 12. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

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For Roster of County Medical Societies
See Issues of Alternate Months Beginning with February

A Look at Ohio's Vital Statistics Record

The Ohio Department of Health recently issued its 1968 Annual Report on Vital Statistics, which shows that the birth rate has remained about the same compared with the previous year and that the rate and number of fetal and infant deaths has declined.

The total population of Ohio as of July 1, 1968 was estimated at 10,784,388. Tables in the report break down the population by counties and by major cities.

There were 185,580 births, a slight increase of 0.2 percent in number, but a rate (17.2 per 1,000 population) the same as the previous year.

The number of deaths was 102,928, a 5.0 percent increase and a rate increase of 4.4 percent (9.5 per 1,000 population).

Fetal deaths amounted to 2,467, a 2.4 percent decrease over the year before and a 2.2 percent rate decrease (13.3 per 1,000 live births).

The number of infant deaths was 3,768, a decrease in number of 1.4 percent from the previous year. The rate was 20.3 per 1,000 live births, a decrease of 1.5 percent.

Ohio recorded only 49 maternal deaths, a rate of 2.6 per 10,000 live births. This was one less than for the previous year, but the rate was down 3.7 percent.

Marriages numbered 87,361, or 8.1 per 1,000 population. The number was up by 5.3 percent and the rate by 5.2 percent.

Divorces and annulments were up also, with 31,256 or a rate of 2.9 per 1,000 population. The number was up 5.6 percent and the rate 3.6 percent.

The report also shows some interesting comparisons of statistics. In 1930 the infant death rate was 61.3 per 1,000 live births, while in 1968 it was 20.3. The decline in maternal mortality rate was most remarkable. The rate per 10,000 live births in 1930 was 57.6 contrasted with 2.6 in 1968. In 1930, 24.8 percent of live births were in hospitals, whereas in 1968 the percentage had progressed to 99.5.

The resident death rate per 100,000 population for the five leading causes of deaths was indicated as follows: Heart disease, 382.2; malignant neoplasms, 162.0; cerebrovascular diseases, 108.0; accidents, 50.0; influenza and pneumonia, 31.2.

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Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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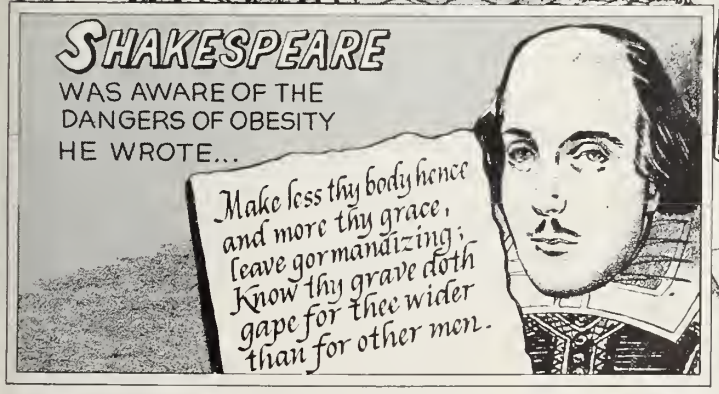
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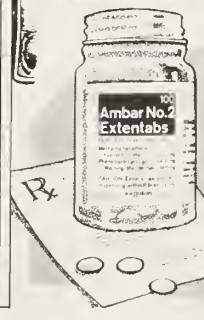
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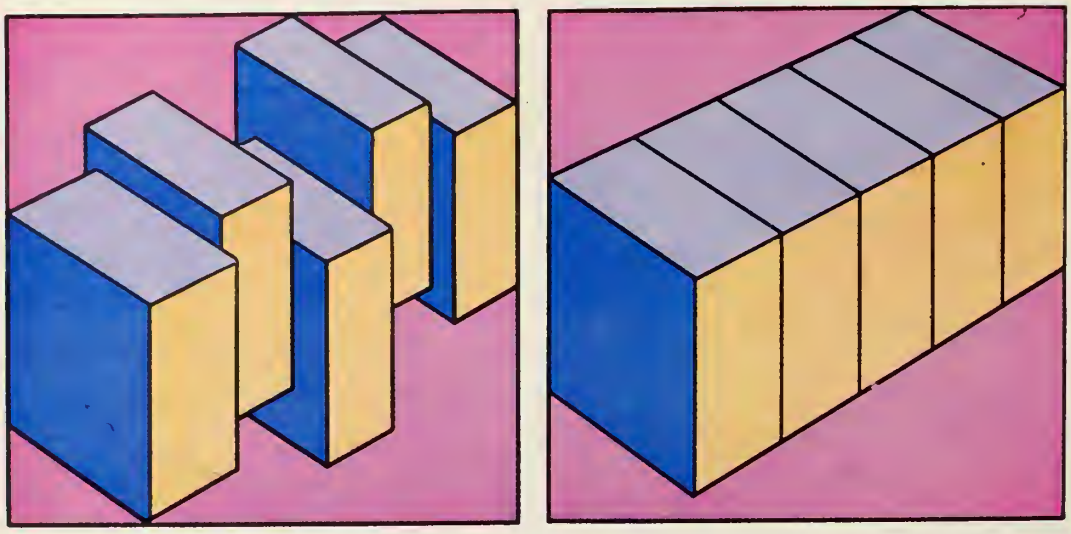
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PRECAUTIONS: In the elderly and debilitated, and in children over six, limit to smallest effective dasage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and talerated. Not recommended in children under six. Though generally not recammended, if combinatian therapy with other psychatropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of patentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence af impaired renal ar hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects an bload coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relatianship has nat been established clinically.
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FEBRUARY 1970
Vol. 66 No. 2

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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24 FEB 1970

Ohioans at Denver...



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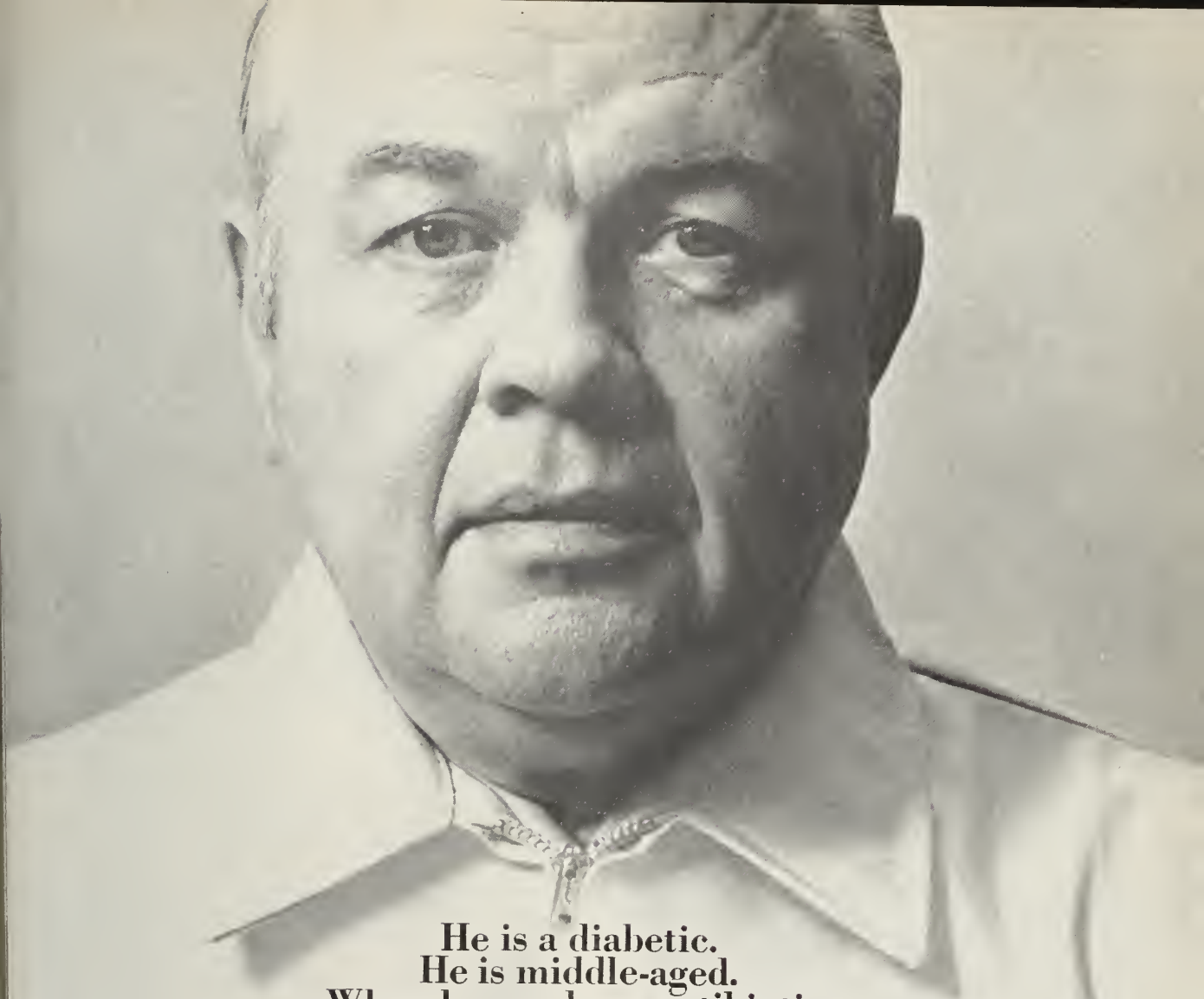
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Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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The Malpractice Dilemma . . .

Insurance Underwriter Lays It on the Line for Doctors Regarding What He Terms "Our Tarnished Public Image"

By Donald L. Wentz, Shelby, Ohio

GENTLEMEN, we are meeting here in a common interest, "our tarnished public image." When politicians clamor for our scalps to the applause of the citizenry, shouldn't this tell us something? Such criticism cannot be dismissed by the mere statement that it is political. Most of the time politicians appraise public sentiments and react to it rather than lead it.

In order for us to understand each other at the onset, irrespective of what I say or how I say it, my aim is to be helpful and objective—not critical nor negative. You, in medicine, and I, in professional liability insurance, had better soon learn to hang together or we most certainly will hang separately. Of prime importance is the fact that insurance companies writing this business are in reality silent partners of the doctors, not in the usual sense of limiting what you can or can't do, and understand that by settling claims which arise only make other doctors a target for easy money. Consequently, unwarranted actions are resisted. I want to make it absolutely and perfectly clear that the Shelby Mutual does not pay money to settle professional liability claims unless and until we are firmly convinced that the doctor has been guilty of some wrongdoing or negligent in his handling of the case.

In our consideration of so-called malpractice claims, the relationship between the doctor and his patient, and the relationship between the doctor and us as his insurer, and the doctor's relationship with the public generally and other members of his profession, is such that in most instances there is a stigma of sorts that is cast by the bringing of malpractice claims or the commencement of a malpractice suit. The doctor becomes emotionally involved inasmuch as it generally relates questions of his professional ability, his professional status, his professional reputation, and, frankly, to properly investigate and evaluate these claims, we too must become emotionally involved. We are doing more than saving dollars when we successfully defend a malpractice suit. We are defending and preserving the reputation and well-being of a highly trained professional individual.

Since the preponderance of professional liability claims allege malpractice—What is malpractice?

What Is Malpractice?

Malpractice is not a vague concept. Actually it is a legal term which has a definite meaning. It might not apply even though the patient suffers an unexpected or unhappy result, a continuing disability, recurring complications or even death. It does apply when a patient sustains an injury because the physician failed to fulfill his legal duty. In simple language, "malpractice" occurs when the physician does something that the ordinary reputable physician would not do; or he fails to do something that the ordinary reputable physician would do.

The courts have attempted to establish and impose standards of conduct upon medical men, and yet if you will think about this a little bit, it resembles a jigsaw puzzle. For instance, the courts rather glibly talk about "standard accepted practice." How can you determine what is standard accepted practice in any field of medicine or surgery, and, once you have determined some standard, how can you apply it? You are individuals and human beings and you are treating and observing other individuals who are human beings. Some of you concentrate on hospital practice and some of you are so situated that you have very little hospital practice or do not have hospital or clinic facilities closely available.

So great have been the advances in medical research and practice that many people (some doctors included) have been misled into believing that medicine has become an exact science. If medicine were an exact science, every tombstone would be sufficient evidence for a malpractice action.

Art and Science

All of this demonstrates that the practice of medicine and surgery is an art as well as a science. It might be described as practice of art based on science and many other things, such as plain, ordinary, everyday common sense, experience, in-

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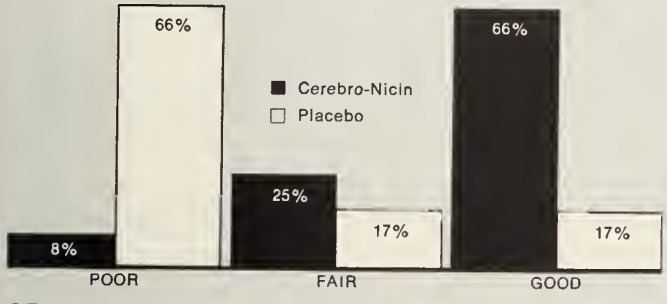
Mr. Wentz is vice-president of the Shelby Mutual Insurance Company, Shelby, Ohio. This article is the transcript of a talk given by him before the Ashland County Medical Society meeting in Ashland on November 6.

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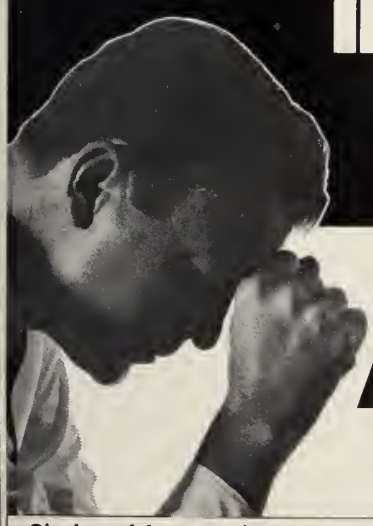
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Fertility and Sterility, January 1970
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Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications—Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. Montesano, P., and Evengelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. **2. Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. **3. Titelt, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. **4. Heilman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. **5. Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. **6. Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. **7. Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

REFER TO PDR

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tuition, perseverance and sometimes luck. It is a truism that some doctors are luckier than others. How many judgements do you make each day? How many ways are there to paint a picture and how many ways are there to look at the same picture?

But the law demands that some standards be set. You are required to meet these standards and therein our problem lies, largely concealed in this great gray atmosphere. Truly, it is not simple to determine whether malpractice has occurred.

The first reported medical malpractice case in the United States dates back to 1794 when a man named Cross, whose wife died following an operation, charged a Connecticut doctor named Guthrey with operating in a "most unskillful, ignorant and cruel manner." A jury found Dr. Guthrey guilty and awarded Cross about $120.

But for 150 years following this historic case, the incidence of medical malpractice suits was relatively insignificant. And even in the early 1930's, such suits could only be classed in the nuisance category. However, by the late 1930's the situation began to change and, after the end of World War II, the incidence of malpractice suits began a steady rise which has now in 1969 reached epidemic proportions.

It is estimated that malpractice claims are being filed at the rate of at least 6,000, and possibly as many as 9,000, per year. According to a conservative estimate of the American Medical Association, one out of every seven physicians, and/or surgeons, in the United States has been sued at least once. In New York and the District of Columbia the ratio is one out of five. In California it is one out of four.

What's Behind It All?

Who is able to say with positive assurance that he knows the reason for, and the answer to, the growing adverse public opinion that is building up against a time-honored and revered profession. Are we aware that this same adverse attitude has permeated and influenced our courts and juries to such an extent that the old and familiar defenses, rules of evidence and perhaps, even justice itself has fallen by the wayside in favor of the "rule of sympathy" and astronomical verdicts?

General theories include the following:

1. A direct analogy between the present critical automobile situation and the rapidly deteriorating medical scene. Medicine and society have become so intertwined they are inseparable.

2. The impact of the medical series through the medium of TV. Your memory should recall how TV spread the '67 riots by covering them closely: flicked them off in '69 when it didn't.

3. Your portrayal as "infallible demigods" by imaginatively emotional writers, sensation mongers and movie scenarios; and

4. The public image of the American Medical Association is an old one, and a simple one: A group of doctors concerned mostly with getting their fees and keeping the government out of their lucrative business. This image was not enhanced when at the most recent association meeting, held in the Americana Hotel in New York this year, Dr. Kunnes accused the association of being an association of "criminals" who provide a dual system of health care—"one for the rich, and another system for everyone else," that the letters "AMA" stood for "American Murder Association," a statement later tempered to "American Manslaughter Association," only because, he said, "the AMA had not premeditated the deaths."

Evolution in Practice

Additionally there is ample evidence in support of the following items which are offered for your consideration as respects this problem.

1. The change from the general practitioner to the specialist; the change from the friendly family doctor to the impersonal specialized professional who has little time for human interest and personal relationships. Although the numerous public and private health and welfare programs and insurance plans go far toward taking the sting out of the money bite, absolutely nothing can assuage the personal hurt inflicted on an ailing individual and his close relatives by a detached attitude or callous approach to his problem. These are the people who, one day, will be called to sit in judgement on error, negligence or mistake alleged to have been committed by some doctor. Their memories are long, their recollections vivid and they do not care very much that the doctor on trial is unrelated to the one with whom they had a sorry experience—real or fancied.

2. The evolution of medical practice from an art to a science, involving the use of drugs, techniques and procedures unheard of a generation ago, and all expensive. Handling of a surgeon's scalpel can restore to full activity a patient whose life is in jeopardy. But when people visualize a doctor as a mechanic who unfailingly can repair or even replace damaged parts of their bodies, they are wrong. The human body is not a machine! During the past 25 years, there has been a growing assumption by many, that all ailments can be cured. *The Reader's Digest,* the Sunday supplements, and

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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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the news releases proclaiming wondrous results from drugs developed by one pharmaceutical manufacturer after another have not helped. With the miracle of medicines that are very new, operative techniques that are very very clever, aided and abetted by highly sophisticated electronic instrumentation, surely there can be no such thing as failure. Inclusion of an doctrine of *res ipsa loquitor* in medical malpractice pleadings is an outgrowth of the no-failure-tolerated concept. The doctrine reverses the traditional need for the plaintiff to establish a clear-cut case against the defendant and instead makes it necessary for the latter to disprove the allegations. The mere fact that the procedure didn't work out speaks for itself according to this theory. Put another way, one is guilty until proven innocent.

Additionally, the traditional relationship between the doctor and the drug maker has been radically altered. Instead of supplying the products the doctor orders, the manufacturer now tells him what he should order and why.

More subtle and more serious, and therefore more controversial, is the effect of the drug industry on the character of medical practice. As is known, the new drugs have served the doctor well. They have equipped him with invaluable weapons against infectious diseases and some emotional disorders. As they have increased his effectiveness, they have increased his productivity and his income.

On the other hand, the doctor has found it difficult to keep up intelligently with the therapeutic qualities of the mounting flow of new products. The knowledge of drugs he acquired in medical school is often obsolete. Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association in 1961, reported that 90 percent of the drugs then prescribed have been introduced in the last 20 years; 40 percent could not have been filled five years ago. The life span of the average drug is said to be two to five years. The turnover has been running at a pace to overwhelm the competence of the average practitioner.

And then there comes The Pill. This item is causing problems. The allegations run to the point that had the doctor informed the woman of the possible side effects, she would have used another kind of contraceptive.

The interesting point here is that it (The Pill) was prescribed at the patient's request and usually was not given for an existing disease. Other drugs with side effects generally are used only if the benefit to the patient's existing medical condition outweighed the possible adverse reaction; but with birth control pills there generally was no medical need and, therefore, no weighing of calculated risk was possible.

3. The problem attending "ghost surgery" is not prevalent in Ashland County so we will pass it by, except for this quick comment—the technology of American Medicine is probably the most advanced in the world, but it's not perfect. It's not human enough. A man is referred to a specialist by his doctor. He is tested and processed. The specialist sees him for 15 minutes and again for a few minutes before he goes into surgery. A man facing surgery is not only sick, he's afraid. If he doesn't get the personal treatment his spirit needs, if he doesn't get the physical results he wants, he is emotionally conditioned to sue. Medical service should be a most personal kind of service; but increasingly it isn't.

4. The virtual abolition of house calls and the feeling that the doctor regards the patient more as a number than as an individual. The doctor-patient relationship is less personal than it used to be. In this age of specialists and of antibiotics and other modern therapies, many patients are apt to see each of several specialists only once or twice, rather than getting the whole attention of one doctor. Therefore, instead of being grateful for being cured, the patient expects to be cured, and resents any delay or deviation on the road to recovery.

The Insurer's Responsibility

The above selected items indicate in part why the publicly held image of individuals practicing the healing arts has retrograded in inverse ratio to the increasingly impersonal practice of medicine at very great cost.

Your silent partner, the insurance company, is in the position of trusteeship of the premiums paid to it by the general public. As trustees, claims representatives have the obligation to prevent unjust enrichment of one segment of the public at the expense of our policyholders. Justifiable measures to prevent fraud are a necessity.

In the next place, since no settlement can be entered into without the approval of our insured, he must be kept posted as to the merits of the case and the recommended action under the circumstances. Seldom, if ever, are nuisance settlements effected in malpractice cases since the insured's reputation is at stake and any indication of guilt is to avoided if possible.

Defense costs in this class outstrip those in any other by a wide margin. Medical malpractice cases are customarily very complicated and unless they are assigned to the most sophisticated legal talent available, the prognosis for a successful defense is pretty grim. Really good medicolegal ex-

perts are rare and their fees correspondingly high. They must be supplied with high powered ammunition by way of professional medical specialist witnesses. They require extensive exploration of every detail that could possibly be meaningful on trial day, because as of that day it becomes too late. It is obvious that even a defendant's verdict in this class is achieved at very substantial cost.

Many times the question of damages is the only thing to be determined, and here the understanding of the insured is needed so that, even if the liability is clear, the settlement to be made can be kept within proper limits. No concession to pressures to dispose of claims quickly at any cost, regardless of the damages involved, should be entertained.

The Long View

The very nature of your endeavor creates special problems for the insurance company, not the least of which is the fact that there is no way for us to know whether we are making money. The horrible truth of this statement can be gathered from the following: In the March 1967 edition of *The Insurance Law Journal,* Frederick O. Field, legal counsel of the Los Angeles County Medical Association, gave an analysis of the program for his association. He took the policy year 1960 and showed the percentage of claims as they were actually reported against this policy year:

1960— 7.4%	1963—16.1%
1961—44.5%	1964— 2.4%
1962—28.4%	1965— 1.2%

At the very end of the article he said, "This company may yet have new and additional claims against the policy year 1960."

To me a medical professional liability policy is known as "insurance with a tail." By that, I mean that in certain instances the policy will have long expired, showing an apparent underwriting profit, and then years later, a malpractice suit will develop where there was no previous knowledge of any claim possibility. For example, 13 years after a policy had expired, a big new reserve need be established on a late discovery of a claim—a child whose arm is now withered and it is alleged was hurt in childbirth.

Why doesn't the statute of limitations protect the company? State after state has made so many exceptions that you can practically say that the statute has disappeared. In many states the statute of limitations does not begin to run until the date of discovery of the injury by the patient. The case may be taken out of the statute of limitations applicable to torts and negligence by construing the case as one involving a breech of an agreement or warranty to cure—to provide competent medical care—to use proper skill.

To generalize, bad cases only seem to get worse and worse as the years go on and with regard to expenses, no one can adequately assess the long term cost in expenses in a technically complicated late developing malpractice case. This fact when added to the late discovery cases, produce results which can be two or three times the best calculated reserves for "incurred but not reported" statistics. There is no way of calculating an adequate premium to take care of the expense.

Some Suggestions

To move from a constricting market to a willing stable market, it is essential that something be done soon. May I suggest to you that most of this constricting market or capacity problem is not grounded in the inability of underwriters to respond because of a shortage of capital funds, but instead results directly from the strong



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Serum Potassium Levels (in mEq./L)

Number of patients	Mean initial value	Mean final value
14	3.23	4.83
16	3.50	4.40
25	4.52	4.47

K-Lyte can offer effective potassium supplementation without the gastrointestinal complications sometimes associated with potassium chloride tablets and thiazide-potassium chloride combination therapy. Effervescent K-Lyte is taken in solution, speeding up absorption to avoid these hazards.

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color.
Contraindications: When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted.
Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.
Side Effects: While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum.
Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement.
How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

*Reports on file: Medical Research Department, Mead Johnson Laboratories, Evansville, Indiana 47721

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feeling that one's capital funds should not be committed to an enterprise where the prospect of profit is dubious.

So now what to do about it? In the final analysis, it is the physician himself who is responsible for the continuing existence of the vicious malpractice situation.

The following circumstances appear to provoke the nuisance malpractice suits:

1. Failure of the physician to exercise tact in his contacts with the patient and the patient's family;
2. Over-optimistic prognosis and promising too much to the patient;
3. Personality clashes between the doctor and patient;
4. Misunderstanding over fees or excessive fees;
5. Use of irritating fee collection methods; and
6. Criticism by a physician of the treatment given by the patient's former doctor.

The most common causes that fall into the valid malpractice category are those in which a doctor:

1. Cuts something that should not be cut;
2. Attempts to do something he is not qualified to undertake;
3. Fails to call in a consultant when indicated; and
4. Delegates important duties to unqualified assistants for whom he is responsible.

Therefore, to prevent nuisance suits, the intelligent cooperation of doctors and patients is essential. All patients must realize that practically nothing in medical practice is absolutely safe or certain. Almost every procedure in diagnosis, treatment and prevention carries an element of uncertainty and danger. In addition, the patient and the doctor must realize that both are human beings, both can get angry and irritated and uncooperative, and both can make honest mistakes. Certainly the doctor must not be looked upon by his patients—or by himself—as godlike, all-knowing and infallible.

However, there is the real negligence or real malpractice. This is one for the doctors themselves to lick.

Dr. Sabin Honored by Mexican Government

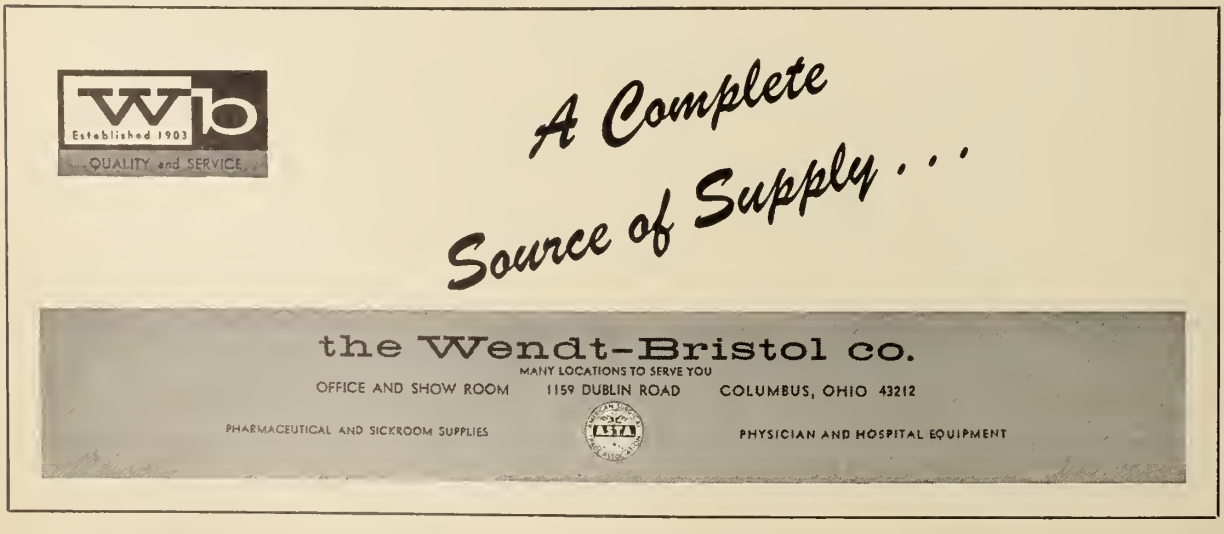
President Diaz Ordaz of Mexico authorized the conferring of the Order of the Aztec Eagle, Mexico's highest honor for a nonresident, on Dr. Albert B. Sabin, of Cincinnati.

Dr. Sabin learned of the award on his recent visit to Mexico as consultant to the Ministry of Health and Public Assistance, a position he has filled for many years.

At the request of President Ordaz, Dr. Sabin was taken to see the chief executive by Dr. Salvador Aceves, minister of health and public assistance and the undersecretary, Dr. Pedro Martinez.

President Ordaz expressed his own gratitude as a parent and grandparent and that of his country for the Cincinnati scientist's help in the production and use in Mexico of the Sabin live virus polio vaccine. A painting of a Mexican child by Jorge Martinez was given to Dr. Sabin by President Ordaz.

The Mexican Embassy in Israel was scheduled to present the award to Dr. Sabin after the first of the year. Dr. Sabin became president January 1 of the Weizmann Institute in Rehovot, Israel. He will maintain his associations in Cincinnati and continue to carry the titles of distinguished service professor of research pediatrics at the UC College of Medicine and fellow of the Children's Hospital Research Foundation.



A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

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Contraindications: Edema, danger of cardiac decompensation, history or symptoms of peptic ulcer, renal, hepatic or cardiac damage, history of drug allergy, history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer, perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may b minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma-

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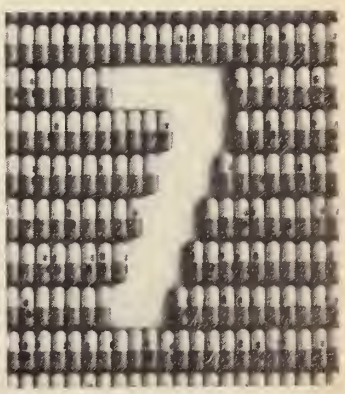
Serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings and contraindications. Read the prescribing information. It's summarized below.

Stevens-Johnson syndrome, s syndrome (toxic necrotizing rmolysis),or a generalized ic reaction similar to serum ess may occur and require anent withdrawal of medica- Agranulocytosis can occur enly in spite of regular, repeated al white counts. Stomatitis arely, salivary gland enlarge- may require cessation of treat- Such patients should not e subsequent courses of the Vomiting, vertigo and languor ccur. Leukemia and leukemoid ons have been reported. While finitely attributable to the a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily. In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-C

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effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Medical Center Library at Ohio State Will Feature Automation

The Ohio State University Board of Trustees acted recently on several major construction projects for the campus, and received reports of contract award recommendations totaling $4,103,049 for a Health Sciences Library.

It also approved plans and specifications for a parking garage — with a rooftop helicopter landing deck — in the Medical Center area.

Ohio State's Health Sciences Library will be one of the most modern and highly automated medical libraries in existence. Site will be south of University Hospital and north of the new Medical Basic Sciences building now under construction on West Tenth Avenue. The board approved plans for the project last September.

The five-story medical library will have 118,000 square feet of space and seating for 1,450 students. It will serve students enrolled in Ohio State's Colleges of Medicine, Dentistry, and Optometry, and the Schools of Nursing and Allied Medical Professions.

A two-story automatic book storage and retrieval system will be a feature of the library.

The unique retrieval system and stacks are designed for 180,000 volumes with an expansion capacity to 220,000.

The library also will have more than 100 study carrels, 11 seminar rooms and numerous study areas. Thirty-one carrels will serve the College of Medicine's computer-assisted instruction program. All seminar rooms and four carrels will be equipped for television with the capacity to receive eight programs simultaneously from all points in the Medical Center.

The library will contain 25 booths connected to the university's dial-access audio and TV system which originates at the Listening Center in Denney Hall. The library also will serve as a base for Ohio State's three computerized bibliographic search programs, known as MEDLARS, C-BAC and SUNY.

The parking garage, the university's third above-ground facility, is planned for a site west of Upham and Means Halls in the Medical Center area. Its five parking floors will accommodate some 1,021 cars.

The helicopter deck will provide landing facilities for the "Medicopter" project through which some 40 critically injured or ill patients have been flown directly to the Medical Center since November, 1967.

Cooperating in the project are the University Hospitals, the Ohio Highway Patrol, and the Ohio Army National Guard.

The helicopter evacuation service has provided service principally to weekend traffic accident victims, but others such as heart patients and victims of plane crashes also have been aided.

At present the helicopter lands on athletic fields west of the Medical Center. The parking garage landing facility would include a special elevator for quick transfer of patients to the hospitals.

Two University of Cincinnati faculty members won the annual prize paper award of the Central Association of Obstetricians and Gynecologists. They are Dr. Clarence R. McLain, Jr., and Dr. Paul T. Russell. Their paper dealt with amniographic studies in complications of pregnancy related to high blood pressure. Dr. McLain presented the paper at the organization's annual meeting in Memphis, Tenn.

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December 2, 1969

Gentlemen:

The article "Sanity and Survival" in the November issue of the OSMJ certainly deserves comment.

What Dr. Frank has said, in essence, is that survival per se is the most important function of man. Love of God, love of family, and love of country are, according to Dr. Frank, quite secondary to survival.

Dr. Frank speaks of the horrors of nuclear war. What about the horrors we would face if we failed to defend ourselves and fell victim to Communism? Murders and tortures in their hands have reached proportions in numbers and degree of cruelty that make nuclear war look like child's play.

Let's keep the OSMJ a scientific journal. Particularly let's keep out of our journal the atheistic, one-world type of tripe such as "Sanity and Survival." For those who want such material, it is readily available in the Communist Worker and many other left-wing publications.

Sincerely,
(Signed) Philip E. Binzel, Jr., M.D.
Washington Court House, Ohio

[Dr. Frank replies:]

December 11, 1969

Dear Sir:

My article drew attention to the fact that, with the advent of nuclear weapons, the traditional reliance of all nations on force as the ultimate way of defending their values threatens the survival of humanity. If this is not a legitimate concern of physicians, who are dedicated to the preservation of life and health, I do not know what is.

I also tried, in an inevitably inadequate fashion considering the present state of ignorance, to cite some sociopsychological considerations that suggest new ways, compatible with survival, by which all nations could achieve security.

It is regrettable that, instead of offering constructive criticisms of these ideas, Dr. Binzel chose to respond with an irrelevant political polemic.

Sincerely,
(Signed) Jerome D. Frank, M.D.

November 28, 1969

Perry R. Ayres, M.D.
Ohio State Medical Journal

Dear Dr. Ayres:

I wonder if it would be possible to insert in the Ohio State Medical Journal the following request,

History of LE Cells

For historical reasons would appreciate the notes or Xerox copies of same of Dr. M. M. Hargrave's lectures given during the American College of Physicians Course Three for Clinical Medicine with Emphasis on Hematology, held at Ohio State University February 14th to 19th, 1949.

J. R. Haserick, M.D.
University Hospitals
Cleveland, Ohio

I would be most appreciative if you could insert this notice.

Yours very sincerely,
(Signed) John R. Haserick, M.D.

Dr. William H. Lippy, Warren, recently received top national honors from Hadassah, the Women's Zionist Organization of America, and was presented the Myrtle Wreath Award. Dr. Lippy's selection for the award resulted from outstanding service in leading an otology team to Israel last summer where American techniques in medicine and surgery were demonstrated.

Dr. Arnold M. Weissler, professor of medicine at Ohio State University, has been appointed to the Gustav Hirsch Memorial Professorship in the College of Medicine. He is the first to hold the professorship, which was established in 1966 by Miss Irene Hirsch through the Central Ohio Heart Association.

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OSMA's Position on Medicaid Presented Before Ohio Legislative Committee

By Robert N. Smith, M.D., Toledo
President, Ohio State Medical Association

CHAIRMAN POTTENGER and Members of the Committee, I am Robert N. Smith, a practicing physician from Toledo, Ohio, and President of the Ohio State Medical Association. I appreciate the opportunity to testify before the committee. We wish to commend the committee on the vigorous objective manner in which this investigation of Medicaid is being pursued.

Let me state from the beginning, the Ohio State Medical Association is in agreement with the principle for which Medicaid was established, and that is to provide the best possible care to all needy persons, regardless of the patient's race, color, national origin, or ability to pay.

We are in agreement with the 1967 position taken by HEW in its "Report to the President on Medical Care Prices," which stated "Charity medicine is being abandoned in favor of new public programs which give needy people the resources to purchase medical care from private physicians and hospitals on the same basis as more affluent citizens."

Health Care Is Big Business

The Health care industry is now the third largest in the nation; $55 billion is being spent this year. By 1975 health care industry will be the largest industry in the nation.

Physicians are most concerned about the cost of health care, not only in regard to Medicaid, but in regard to the total health picture.

As evidence of this concern, the Ohio State Medical Association last February issued a news release calling for an unlimited, nonpartisan national investigation of Medicare and Medicaid, in which we reiterated our long standing position that questionable conduct by physicians, or any persons, should be examined.

At the same time, we sent a telegram to U.S. Senator John J. Williams, a member of the Senate Finance Committee, in which the Ohio State Medical Association urged a full-scale investigation of all aspects of Medicare and Medicaid as administered by the Social Security Administration and the U.S. Department of Health, Education and Welfare. It was pointed out in this telegram that the Ohio State Medical Association has had, even prior to Medicare and Medicaid, a standing offer to any government agency to probe, on request, questions of overcharging, overtreatment or possible unethical conduct by physicians. We have publicly, on numerous occasions, expressed our willingness to cooperate in such investigations. More to the point, we have, when requested by the Ohio Department of Public Welfare, been investigating claims since the beginning of the medical only program in 1935. We also investigate claims for commercial insurance—Blue Shield, Medicare (Nationwide), Bureau of Workmen's Compensation—and use the same mechanism.

The Brunt of Criticism

Physicians, as you know, have been more than somewhat concerned about charges that have been made which accuse the medical profession of causing the skyrocketing costs of the Medicaid program.

Let me make several observations about these charges.

William C. White, Jr., Vice-President, Prudential Insurance Company of America and a member of the HEW Task Force on Medicaid and Related Programs, stated recently that Congress was misled by administration estimates of costs of health programs, adding that now that Congress is faced with providing financing for open-ended programs, there must be a goat. So, Mr. White said, the medical profession is taking the brunt of the criticism for rising health care costs.

How realistic are these charges? Last week, some of the evidence was in. Michigan Blue Shield completed an audit of 81 providers of service, including 70 physicians who received $25,000 or more under Medicaid in 1960. Of the $5,245,000 paid out, less than one percent ($52,000) involved possible fraud. Sanford Polasky, M.D., of Benton Harbor, Michigan, was paid $169,000, but a close audit absolutely cleared him of any wrongdoing.

Dr. Smith appeared on November 20 before the Ad Hoc Committee of the Ohio House of Representatives studying the Medicaid program in Ohio. This article is the transcript of his testimony before the committee, with Representative Thomas A. Pottenger, of Cincinnati, as chairman.

However, he was publicly attacked, chastized and received anonymous threats, all because of wrongful publicity. He returned the $169,000 he had received before he was investigated. Every penny was returned to him after the audit.

The New York City Health Department recently announced that its "on site" audits had identified only 207 errant claims out of 15,000 Medicaid providers of service. The Department noted this was an exceedingly small amount.

Few in Ohio

Here in Ohio, according to published information dated March 12, 1969, only four physicians received more than $25,000 for their Medicaid services in fiscal 1968. One was actually a group of physicians, rather than one physician. The other three practiced in economically disadvantaged areas.

For the fiscal year ending June 30, 1969, a State Auditor's report listed seven physicians as receiving more than $25,000. Again, some of these were groups of physicians, and others were providing a significant number of Medicaid recipients the medical care they required. If medicaid is working, we should find the money going into the economically depressed areas.

In a letter to the Ohio State Medical Association from U.S. House of Representatives Ways and Means Committee Chairman Wilbur Mills, dated March 6, 1969, Mr. Mills stated:

"I do not believe that any implications of wrongdoing can be based simply upon the amounts of payments received by a physician under the programs. As you well know, other important considerations would have to be taken into account, including the expenses of operating a physician's office and the existence of such arrangements as partnerships, group practice, and clinics."

Mr. Mills strongly commended the Association for its widely publicized stand favoring a full, open investigation.

Lower Percentage in Ohio

Nationally, physicians fees account for 11 percent of the total Medicaid expenditures. In Ohio, the cost of the Medicaid program for physician services is 7.3 percent; hospitals, about 31 percent; nursing homes, 31 percent; and drugs, 13 percent. Normally, physician fees amount to 24-26 percent of the medical dollar.

What physicians find hard to understand is the government's position of expecting to control total costs of the program by imposing restrictions on the part of the program that represents only 11 percent of the costs nationally and 7.3 percent here in Ohio.

It may be true physician fees have increased the past few years, but it has not been proven to us that the increase has been unreasonable in Ohio.

Rent, employee salaries and fringe benefits, the cost of mounting paper work, insurance, drugs, supplies—all the things it takes to run a medical practice—are among the fastest rising items in the U.S. today. The cost of running a practice has increased 100 percent or more in just 10 years, and the rate of increase of overhead continues to be about eight percent annually, according to a prominent medical practice management firm.

In a Social Security Administration publication, dated December 19, 1968, statistics indicated that less than half of the money collected and appropriated for Medical Insurance Trust Fund in the first 18 months of the program was **actually paid out for Part B services in Ohio.** In other words, according to Social Security Administration reports, for each $6 paid in per month, only $2.80 was paid out for benefits. The difference was spent in states like California, where the payment was $7.35 for each $6 paid in.

Exaggerated Reports

I want to repeat for emphasis that there has been abnormal attention about so-called lists of physicians who have received $25,000 or more from the Medicaid program. Regardless of the intent of publicizing names, the connotation is that these providers of care have been dishonest. This would imply that anyone in the United States receiving more than $25,000 in a year is dishonest.

On the other hand, little publicity has been given to the fact that fees paid Ohio physicians for services to Medicaid patients are limited to 60 percent of each physician's usual, customary and reasonable fee.

This 60 percent means, for example, that the physicians paid $25,000 actually contributed $16,000 to Medicaid, since $16,000 represents the difference between the usual, customary and reasonable fee for their professional services, which would be $41,000, and the 60 percent of their fee that they are paid.

If you project this to the more than 9,000 physicians in Ohio who treated Medicaid patients last year, you begin to get an idea of the charitable contributions physicians are making.

Since $7,700,000 represents total payments on a 60 percent basis, 100 percent of payment would amount to $12,833,000, which means a difference of $5,133,000 contributed to the program by physicians through their acceptance of a 40 percent

reduction in their usual, customary and reasonable fees.

Defeating the Program Purpose

These publicized lists of providers of care receiving certain amounts of money from the program have served no useful purpose. Instead, they defeat the purpose of the Medicaid program, which is to help return the economically disadvantaged people to the mainstream of society and medical care.

Further, these lists have influenced physicians not to locate in depressed areas, or to relocate their practices in areas where the Medicaid case load is not so great. This comes at a time when we need to attract more physicians to economically disadvantaged areas.

However, if anybody has any evidence of fraud, excessive fees, padding claims, double standard care, we assure you the physicians of the Ohio State Medical Association are dedicated to the principle that these actions should be brought to light, and that proper remedies be found, including legal action taken where appropriate.

I would call to your attention the fact that the Ohio Department of Public Welfare has, since January 1, 1969, referred only 29 cases to my Association for investigation. The Department takes this action when it wishes to question what might appear to be a charge in excess of a usual, customary and reasonable fee.

These 29 cases represent three-thousandths of one percent (.003) of the 669,000 total claims processed by the Department in that period.

We do, on occasion, run into the situation of the bad apple in the barrel and this makes the entire profession look bad. We do have disciplinary mechanisms within the society and through the State Medical Board to take care of these cases. However, unexplained and nonitemized lists of a few physicians receiving $25,000 or more makes the entire profession look bad, and for no useful purpose. This profession must deliver the medical care of any health care program. At this time the profession is "up tight" over widespread, unsubstantiated public innuendoes regarding the alleged conduct of physicians.

Bring the Patient Into It

After previous hearing of this committee, there has been considerable discussion about the lack of a mechanism for checking whether or not the recipient is getting what the welfare department is being billed for.

I would recommend to you that the best, most effective solution to this problem is to require that the provider of care send his bill directly to the patient rather than to the Welfare Department. The patient then could certify whether or not the services were provided to him. This also would give the patient some responsibility as well as helping him appreciate the cost of services being provided him in the program.

It has been alleged that physicians have refused care to patients, and allegations of double standards of care have been made. There are good and sound reasons for refusal to accept patients. There are just so many hours in a day to see just so many patients. There is no excuse whatsoever for any double standards. Just as the patient has the right to select a physician, the physician has the right to choose the patient he will treat. However, once he accepts a person as his patient, he is legally, morally and ethically obliged to give that person the best medical care the physician can provide.

OSMA Will Review

I would again emphasize that the Ohio State Medical Association has (and had even prior to Medicaid) a standing offer to any government agency, third party or patient, to probe, on request, questions of overcharging, overtreatment or other possible unethical conduct of physicians.

Your committee has discussed the duty of the physician to care for his fellow man, regardless of whether or not he gets paid. Historically, you will find that, even before Medicaid, welfare recipients were being cared for at little or no cost to the state.

Even now, with Medicaid, where the Federal and State governments have undertaken to pay the health bills of those on welfare, physicians are subsidizing the medical care portion of the program by approximately 40 percent. Little credit has been given the profession for this significant contribution.

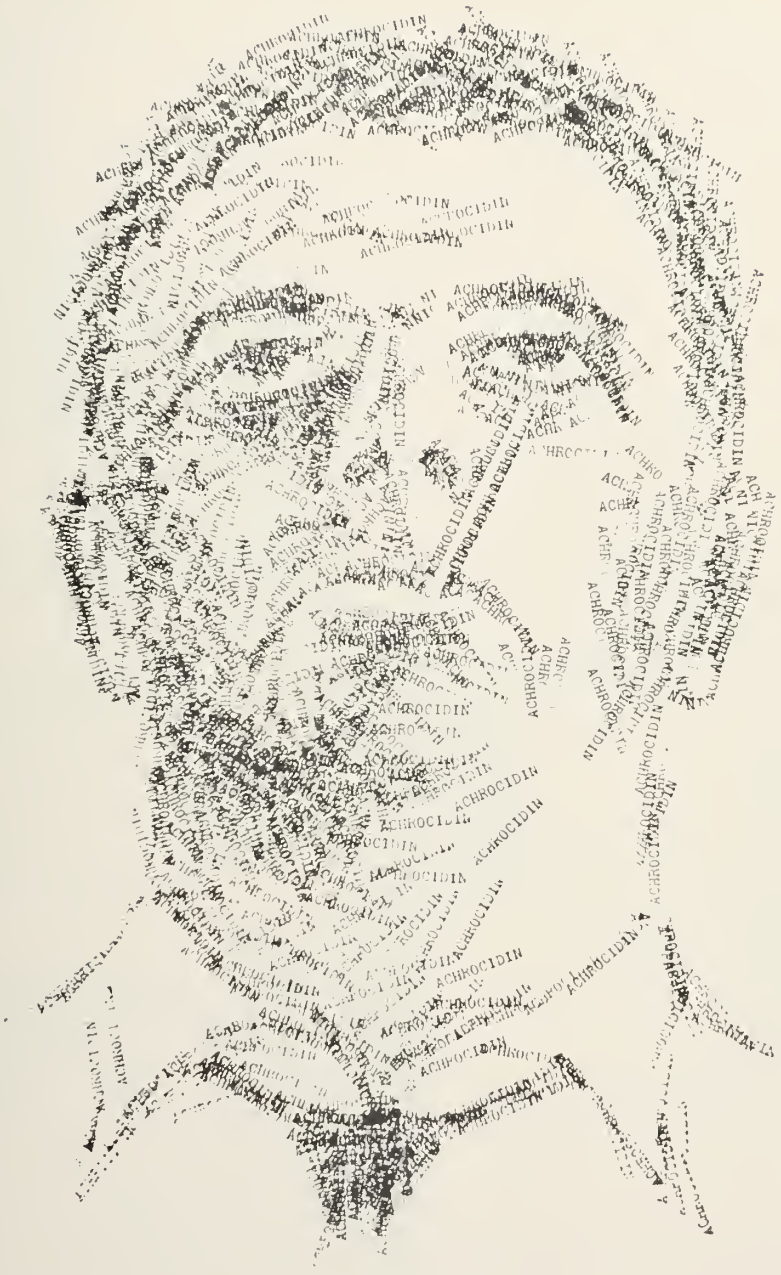
Still There Is Charity Medicine

There is also considerable charity medicine in Ohio. You have heard testimony that, if the medically indigent were to be included in the Medicaid program, $200 million would have to be added to the budget. Physicians of Ohio are now caring for these people with little or no reimbursement for their services.

There are reasons why physicians and other providers of service are asking to be paid reasonable amounts for their services. Perhaps you are not aware that the overhead costs of medical practice have increased over 100 percent in ten years. Salaries, taxes, rent, astronomical increases in malpractice insurance, and many other items, have increased dramatically in cost. But these are factors the patient and the public are not aware of.

There is a point where every physician must limit the number of charity cases he has in his practice if he is to stay in practice.

Also, I am aware that some well-meaning people feel that a solution to the cost of the Medi-



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Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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caid program lies in the development of a fee schedule. Let me take a moment to explain to you the advantages of a usual, customary and reasonable fee as we have developed it in Ohio. Our experience, through private and voluntary health insurance, and through certain other government programs, shows clearly that this method of reimbursement is, in fact, less costly than a statewide fee schedule.

I will close by repeating a statement that I have made on several occasions. The principle of helping those who need help is a vital, necessary concept that must be saved. It is high time that government realizes this. Our needy Americans have too much at stake for us to do otherwise. Therefore, any changes in Medicaid, or any substitute program, must meet their needs. Likewise, it also must enable full and positive participation by the physicians who provide their professional services.

Thank you again for the opportunity to testify.

NIMH Launches Quarterly on Drug Dependence

A new publication has been inaugurated by the National Institute of Mental Health to facilitate the dissemination and exchange of information in the field of drug dependence.

The new quarterly journal, *Drug Dependence,* is prepared jointly by the Institute's Division of Narcotic Addiction and Drug Abuse and its National Clearinghouse for Mental Health Information to answer a recognized need for a professional publication in this area. The journal will serve scientists of many disciplines, legislators, lawyers, teachers, students, and others.

Copies of *Drug Dependence* can be purchased for 50 cents each from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Fifty Year Group Seeks New Members

The Fifty Year Club of American Medicine now has approximately 350 members, but its officers point out that there are many more physicians who are eligible for membership.

Dues are nominal. During the American Medical Association Annual Convention each year the group holds a luncheon and has a speaker.

Persons interested in more information are invited to contact Davis W. Goldstein, M.D., Secretary-Treasurer, 100 S. 14th Street, Fort Smith, Arkansas 72901.

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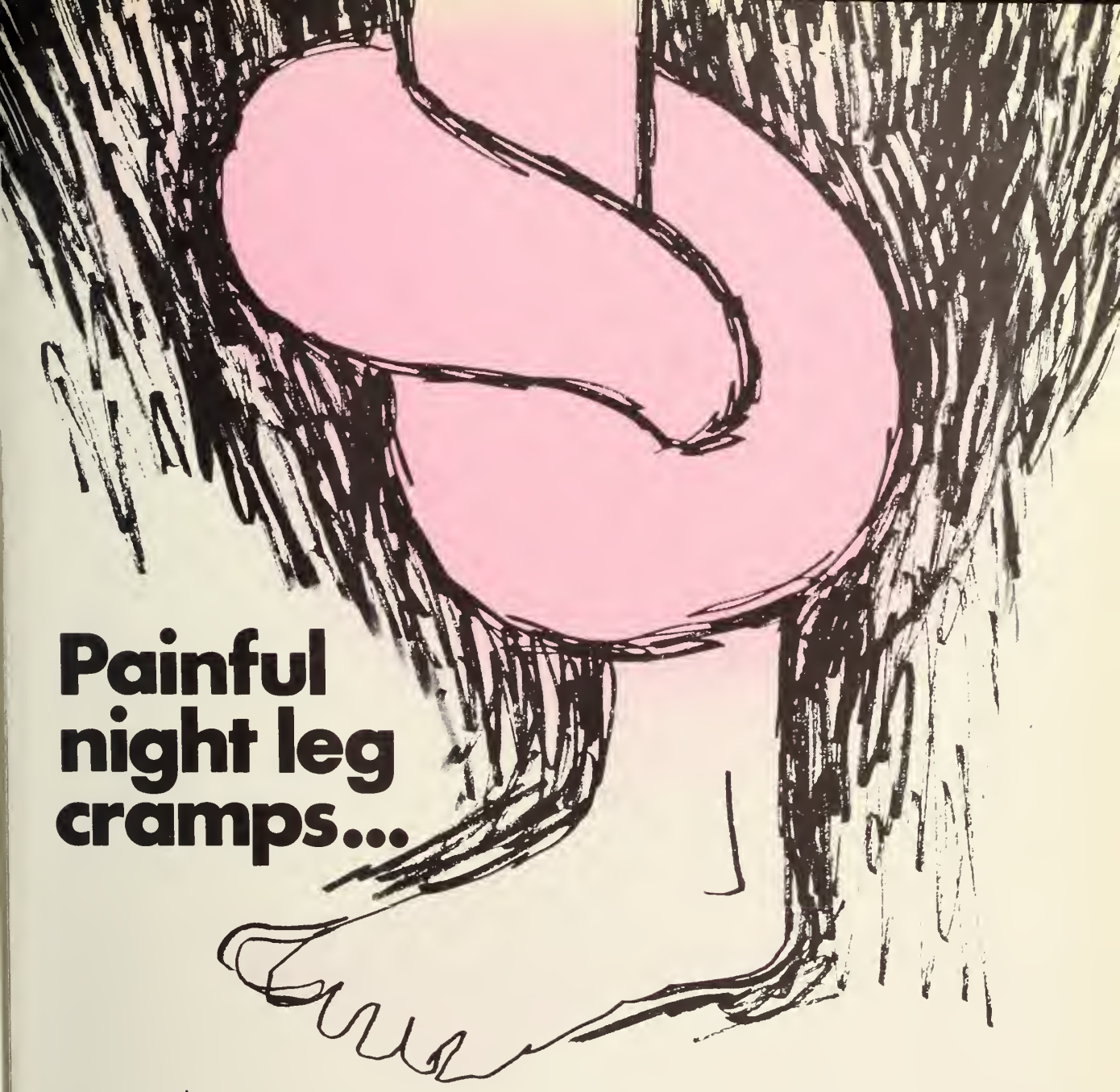
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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

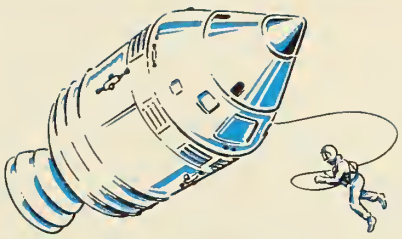
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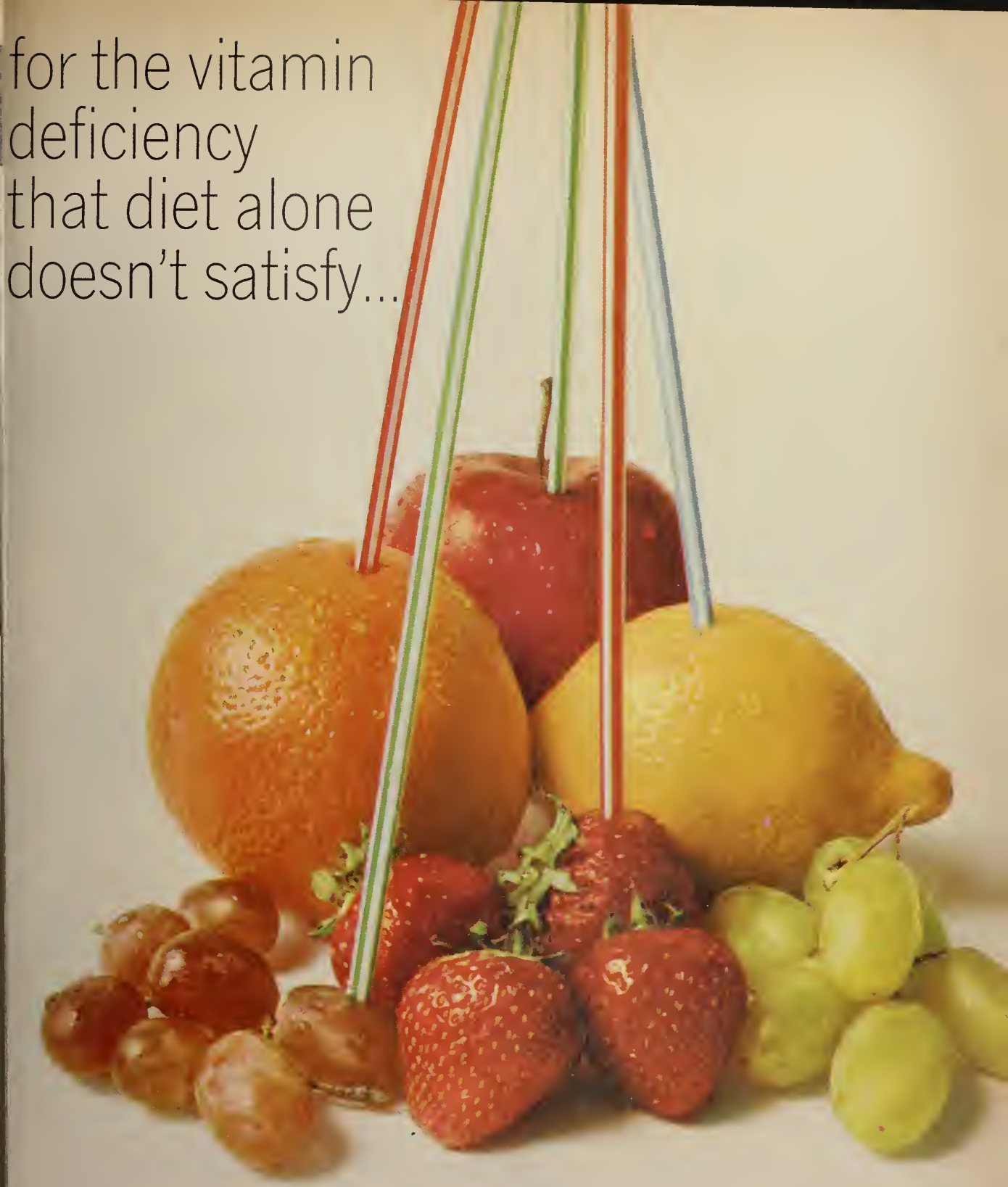
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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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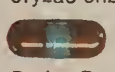


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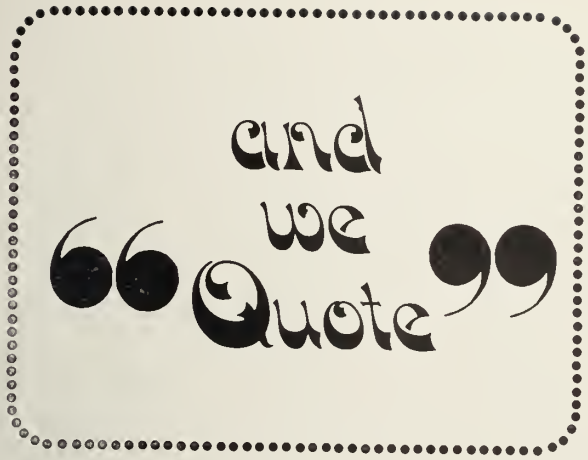
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An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT *is the leading cough preparation of its kind.* BENYLIN EXPECTORANT *tends to inhibit cough reflex ...soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes* BENYLIN EXPECTORANT *easy to take.*
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Putting Positive Emphasis on Sex Education

"The human body is not a 'dirty joke.' Nor should it be the subject of pornography. But isn't it?

"Particularly in larger cities, one is hard put to escape theatre marquees, cinema posters and bookshelves extolling in both words and illustrations the glorification of sex as the forbidden fruit. According to some, this is the permissive society, the age of Aquarius, the sexual revolution, the spouse-swap, the promiscuous conquest, the 'self-expression' experiment.

" 'Experiment' is the key word.

"Should young people, and indeed their parents and other adults, have to 'experiment' with human experiences and find vicarious satisfactions through distorted concepts presented on the stage, page and screen?"—PRDoctor, AMA, Nov.-Dec.

Pharmaceutical Industry Grows; Corner Drug Store Fades

"But now, Karl Mueller has called it quits. After taking home only $3,000 last year on sales that had fallen to $73,000, the elderly proprietor first tried to sell the business and then, failing that, sold off his inventory and turned the store back to the landlord early this year.

"What happened to Mr. Mueller since 1962 explains some of the reasons why the small corner drugstore is fast disappearing from many urban areas as the problems of urban crime, social change and tougher competition multiply.

"Rent and city real estate taxes, which Mr. Mueller shared with his landlord, rose 35% between 1962 and this year. The weekly union wage Mr. Mueller paid his pharmacist increased to $220 from $140. E. J. Korvette Inc., Spartan Industries Inc.'s big retail discount chain, opened a large outlet a half mile away and began selling drugs, health and beauty aids at prices well below Mueller's. Many of Mr. Mueller's middle class white customers moved out of the neighborhood as growing numbers of Negroes and Puerto Ricans moved in. Vandals broke the pharmacy's windows and ripped its awnings on several occasions.

"The experience has left Mr. Mueller bitter and withdrawn in his retirement. (Mueller isn't his real name. "I've had nothing but trouble, and the last thing I want now is publicity," he says.) He apparently has plenty of company.

"There are about 625 drugstores in Philadelphia today, down from about 1,475 in 1945. Chicago loses about 50 pharmacies a year. Brownsville and East New York, two vast and congested poor areas of Brooklyn, are served by only 12 drugstores, a decline from 70 in 1957.

"All this means that a city resident, who used to be able to get a prescription filled and delivered late at night by a drugstore on a nearby corner, often finds himself many blocks or miles from the nearest store."—David McClintick, Staff Reporter of the Wall Street Journal.

Seeks Fundamental Reorganization of Health Care System

"When at bargaining tables in the forties we talked about Blue Cross, we were accused of advocating socialized medicine. We worked hard to build Blue Cross, but we must move on to develop a new instrument . . . a uniquely American system, comprehensive, high-quality care on a universal basis . . . (that is) fully compatible with the values of a free society.

"We are not trying to create a master plan. Our objective is to bring about a fundamental reorganization of the health care system so that access to good health care for all Americans is indeed a right."—Walter Reuther, as quoted (in part) in the Newspaper of the National Association of Blue Shield Plans.

They Say It Really Happened

"The Denver Better Business Bureau began receiving complaints from frustrated customers trying to obtain satisfaction from a local service firm. Each time they called the firm, they were told that, 'Mr. Chiwawa, our complaint manager, is tied up in the back and can't come to the phone.'

"As is customary, the BBB followed up the complaints and found the statement to be true—precisely to the letter. 'Mr. Chiwawa' was a Chihuahua dog, and he was kept tied up in the back room so he was never able to come to the phone."—BBB Beacon.


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
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Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

When protein is the focal point in your patients' special diets, Campbell's Soups can be a convenient supplementary source of that essential nutrient.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 365, Camden, New Jersey 08101.

There's a soup for almost every patient and diet ..for every meal and, it's made by Campbell



LOMOTIL®

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Each Lomotil tablet and each 5 cc. of Lomotil liquid contain:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

One hundred per cent of all travelers who have traveled 200,000 miles or more away from home have relied on Lomotil to control diarrhea.

When your patients need a reliable antidiarrheal—at home or away from home—rely on Lomotil.

In diarrheas associated with:

- gastroenteritis
- acute infections
- functional hypermotility
- irritable bowel
- ileostomy
- drug-induced diarrhea

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

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UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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RESEARCH Protocols

Use of PCO to Ameliorate Toxic Effects of Nitrogen Mustard and Azathioprine

PCO designates a deproteinized material derived from baker's yeast. It increases the oxygen uptake of cell suspensions and tissue slices as measured in the Warburg respirometer. It also overcomes the depression of tissue respiration caused by cyanide, azide, mercurial germicides, etc.

Current research is directed to the action of PCO in ameliorating the toxic effects of nitrogen mustard and azathioprine (Imuran). PCO, of low toxicity for mice, rats, rabbits, and dogs, protects mice against the lethal effects of nitrogen mustard with the maintenance of antineoplastic activity against Sarcoma 37 and lymphatic leukemia BW5147. Of particular note is the ability of PCO to maintain the leucocyte count and apparently protect the bone marrow from damage by nitrogen mustard.

In dogs it was noted that maintenance of the total white count by PCO was accompanied by a decrease in the proportion of lymphocytes. This suggested the possible use of PCO as an immunosuppressive agent. Studies of renal allografts in dogs showed that while PCO by itself did not improve survival rate, in conjunction with Imuran, survival rate was significantly lengthened (survival times, days: control, 9.25 ± 0.2; Imuran, 14.6 ± 0.7; Imuran plus PCO, 22.6 ± 1.4). This was accompanied by improved renal function, a lessened histologic picture of rejection, and bone marrow protection. Preliminary experiments have also demonstrated the usefulness of PCO in kidney preservation prior to transplant.

Research under way (at the Institutum Divi Thomae in Cincinnati) involves fractionation of PCO to isolate and identify the active substance(s). Results to date indicate that the different physiologic activities of PCO can probably be attributed to different substances. The mouse tumor studies will be extended to determine the best procedures and dosages and to include other tumors and other antineoplastic agents. Research under way (at Roswell Park Memorial Institute in Buffalo) includes further renal preservation investigations, use of PCO with other immunosuppressants, studies on immunologic aspects of the mechanism of action, the use of PCO in skin and kidney grafts in baboons, and studies on bone marrow protection in mice receiving whole-body radiation.—George S. Sperti, Sc.D.; Elton S. Cook, Ph.D.; Leo G. Nutini, M.D., Cincinnati; and Gerald P. Murphy, M.D., Buffalo, N.Y.

Generic and Trade Name of Drug
Azathioprine—Imuran (Burroughs Wellcome & Co.)

CHRONIC EOSINOPHILIC PNEUMONIA. — Nine women presented an unusual and distinctive syndrome consisting of a chronic and ultimately life-threatening illness with high fever, night sweats, weight loss and severe dyspnea. Tuberculosis was the initial diagnosis in most cases, but the patients' condition deteriorated on chemotherapy. Asthma occurred for the first time with the onset of the illness in six patients, whereas three had neither asthma nor blood eosinophila. The roentgenograms showed characteristic, rapidly progressive, dense pneumonic infiltrates arranged in a peculiar peripheral pattern best described as a "photographic negative" of the shadows seen in pulmonary edema. Chronic eosinophilic pneumonia was recognized from the consistent pathological pattern of the lung biopsies. Corticosteroid therapy caused complete clinical recovery and clearing of the roentgenograms within a few days. With premature reduction or omission of therapy symptoms recurred, and the infiltrates reappeared precisely in the same locations. Long-term follow-up observation suggests that, although this process may progress to fibrosis, the prognosis is generally good.—Charles B. Carrington, M.D., Whitney W. Addington, M.D., Anne M. Goff, M.D., Irving M. Madoff, M.D., Asher Marks, M.D., Jules R. Schwaber, M.D., and Edward A. Gaensler, M.D., Boston: *The New England Journal of Medicine,* 280:787-798, April 10, 1969.



Professional Activities

American Medical Association Establishes Committee on Private Practice

FOLLOWING ACTION instituted by the Ohio State Medical Association, the American Medical Association at the Denver Convention established a Committee on Private Practice, a function of which shall be "to encourage and promote the private practice of medicine." On floor action, the committee was established as a Standing Committee of the Council on Medical Services, a council of the AMA House of Delegates.

Action in this regard started with Resolution No. 21, passed by the OSMA House of Delegates at the 1969 Annual Meeting. The resolution set the stage for establishment of the OSMA's Council on Private Practice (see October issue of *The Journal,* page 1033).

In keeping with the resolution of the OSMA House of Delegates, the Ohio delegation to the AMA introduced a resolution at the New York convention in July advocating an AMA Council on Private Practice. The AMA House of Delegates referred the Ohio resolution to an Ad Hoc Committee with instructions for it to study the proposal and report back at the Denver meeting.

At the Denver meeting, the House Reference Committee on Amendments to the Constitution and Bylaws considered the report of the Ad Hoc Committee, a report of the AMA Council on Medical Services, an Ohio resolution, and a Louisiana resolution—all pertaining to private practice.

In lieu of the Ad Hoc Committee's report, the House reference committee offered the following substitute resolution, which, after amendments on the floor, was adopted as follows:

Whereas, The private practice of medicine is still believed to be the best method of serving mankind's medical needs; and

Whereas, There is no specifically designated method in organized medicine for the promotion of private practice; therefore be it

Resolved, That the House of Delegates establish a Committee on Private Practice, which committee shall consist of nine active members of the Association. The functions of the Committee on Private Practice shall be:

1. To encourage and promote the private practice of medicine;
2. To develop new methods that will promote the private practice of medicine throughout medical school and postgraduate training;
3. To assist the private practitioner to improve his method of providing medical care continually including business practices and the efficient utilization of allied health personnel;
4. To publicize to patients the merits of private practice;
5. To encourage and assist the development of similar committees by state medical associations; and
6. To maintain constant liaison with other committees and councils of the AMA to achieve these objectives.

Ohioan Named to Committee

Among physicians named to the new AMA Committee on Private Practice is Ohio Delegate Robert E. Tschantz, of Canton.

Ohio Spells Out the Need for Top Level Promotion of Private Practice

THE PRIVATE PRACTICE OF MEDICINE is and always has been the best and principal source of delivery of medical care to the people of these United States. Further, it is an incontrovertible fact that the greatest percentage of American Medical Association members and the greatest support of its policies, philosophies, and ideals come from the private practice sector.

Maintaining a Principle

As the House's Ad Hoc Committee to study and recommend House action on the resolution calling for the establishment of a Council of the House to concern itself with private practice so succinctly points out in the report to the House: "The private practice of medicine is still believed to be the best method of serving mankind's medical needs," and:

"There is presently no single structure in organized medicine for the promotion of private practice."

There are ample signs that the diminishing numbers of practicing physicians as well as the advancing age of those that practice have reached a critical stage. When only little more than one-half of the physicians in this country devote full time to the practice of medicine, it calls for the immediate attention and action of all members of the AMA House of Delegates.

For many years there has been evidence of poor support for the AMA from university and nonpracticing physicians. Now, we must recognize that there are ample signs of the dwindling interest of private practitioners in belonging to the AMA.

Recognizing a Need

In 1957, when a nationally recognized professional management firm made a survey of and report on organization and activities of the American Medical Association, that firm reported:

"Many years ago AMA was the one authoritative society of the medical profession. Over the years, as many other medical organizations were formed, it lost that preeminence among doctors. Apparently, as specialization of medical practice grew, physicians found their needs and interests were not being met by AMA. There seemed to be a feeling that the Association was not interested in their problems and a need became apparent for joining with other physicians who had similar specialized interests."

Ohio Presents White Paper

In addition to the resolution on private practice, Ohioans prepared a white paper detailing the urgent need for top level action in regard for preservation of the concept of private practice. The accompanying article is the text of the white paper distributed to members of the AMA House of Delegates over the signatures of Robert N. Smith, M.D., OSMA President; Maurice F. Lieber, M.D., Chairman of the OSMA Council on Private Practice, and the entire Ohio Delegation.

Clearing the Air

So that there can be no further misunderstanding, let it be clearly understood that this resolution does not propose a council on solo practice. Such a proposal would be as ridiculous as proposing a council on group practice, a council on government practice or a council on partnerships.

This resolution recognizes the serious situation, seeks to answer the often expressed criticisms of hundreds of physicians who have withdrawn from AMA membership, claiming "the AMA doesn't give a damn about private practice anymore."

Well, the AMA does give a damn about private practice. The AMA, as the House of Delegates has frequently stated, recognizes that the private practice of medicine has produced the finest system of medical care ever developed.

No one, including governments, has come up with a better system of health care. The very shortage of practicing physicians, which the government more than anyone is responsible for, will be used to destroy private practice.

Powerful Adversaries

The number and power of the declared adversaries of our private practice of medicine are tremendously significant and point up dramatical-

ly the need for this Council. On February 3 of this year [1969], national Blue Cross Association President Walter J. McNerney told the Economic Club of Detroit, "In a word, we do need a new system (of health care), in my opinion, and we should face up now to how to achieve it." Regarding physicians, Mr. McNerney called for, in his words, "negotiated fees or per capita payment."

Before the recent convention of the Association of American Medical Colleges, United Auto Workers President Walter P. Reuther vehemently attacked the private practice as the "non-system of medical care." Mr. Reuther has organized a national pressure group to seek enactment of his universal compulsory government health care program as the "system of socialized medicine."

In his AAMC speech October 3, Mr. Reuther stated, "The American consumer is being compelled to subsidize the waste and inefficiency of a disjointed, disorganized, non-system which has proven itself incapable of providing high quality comprehensive care on a universal basis to the American people." Mr. Reuther flatly told the AAMC, **"We cannot hide the total failure of this non-system."**

New York Governor Nelson Rockefeller openly advocates his plan for national **compulsory** health insurance.

Let there be no doubt, these national health care system advocates will never be satisfied with financing payment for health services. They want to dictate YOUR methods of practice, YOUR fees for YOUR services, even YOUR professional life.

Private Practice Council's Mission

Let there be no doubt that the drive for some type of national health care system will reach gigantic proportions in 1970. This one fact alone brilliantly spotlights the urgent need for a Council on Private Practice to carry out the solemn responsibilities proposed in the report of the House's Ad Hoc Committee, namely:

"(1) To encourage and promote the private practice of medicine;

"(2) To develop new methods that will promote the private practice of medicine throughout medical school and postgraduate training;

"(3) To assist the private practitioner to improve and update his method of providing medical services, including business practices and the efficient utilization of allied health personnel;

"(4) To publicize to patients the merits of private practice over other systems of delivering medical care;

"(5) To bring to the attention of all private practitioners the forces at work to downgrade private practice in contrast with other unproven methods of delivering medical services;

"(6) To encourage and assist the development of similar councils by state medical associations;

"(7) To maintain constant liaison with other AMA councils and committees to achieve these objectives."

The definitely stated finding of the Ad Hoc Committee, namely: "There is presently no single structure in organized medicine for the promotion of private practice," merits immediate, positive action.

The establishment of another Council of the House of Delegates is not a step to be taken lightly. But of greater importance is the urgency of the demand for this council.

Private Practice Council Must Not Be Subordinated

It has been said that the subject of private practice is one that could be assigned to an existing council. However, the dire need for such a council to devote all of its attention and energies toward carrying out those paramount responsibilities enumerated in the Ad Hoc Committee's report clearly show that these activities and responsibilities cannot be subordinated by another already existing council.

This is particularly applicable when one considers the burgeoning programs, assignments and concerns of the present councils. The Council on Medical Education, for example, is faced with finding workable solutions to such problems as increasing medical manpower, increasing allied health personnel, developing faster and more effective methods of moving new medical knowledge from the researcher to the practitioner, financing medical education and medical research, evaluating education and research, establishing a broader spectrum of continuing education, and scores of other responsibilities.

Present Councils Overburdened Now

The Council on Medical Education already has 26 various advisory and liaison committees. It would be grossly illogical to add this additional, serious responsibility to this already overburdened Council. The enormous responsibilities and scope of activities of the Council on Medical Service are almost awesome. This Council currently has four significantly large and important standing committees, any one of which could well be elevated into full council status. In addition, the Council must maintain continuous and effective liaison with such organizations as the American

College Health Association, American Association of Medical Clinics, Medical Group Management Association, and National Association of Blue Shield Plans. To this has been added additional demanding functions, such as consultations with the scores of government agencies currently operating some type of health care program or administering grants for programs, and consultation regarding the hundreds of Congressional bills that involve health care and medical services.

Therefore, it would not be practical to add to the many missions of the Council on Medical Service the considerable responsibilities and functions of the proposed Council on Private Practice. To do so would tremendously dilute the important and undivided attention and projects that should and must be devoted to the private practice concept by the distinct, undiluted advantage of a free-standing Council on Private Practice, responsible directly to the House of Delegates.

Source of Most AMA Supporters

In summary, it can be successfully demonstrated, with logic, with certainty, with accuracy, without bias, that a council to promote and advance that type of practice engaged in by a vast majority of those AMA members who, through concrete pecuniary means and personal philosophy and actions, make possible that national group known as the American Medical Association.

The establishment of this Council on Private Practice could well speed the return of our Association to that stature described 114 years ago by that medical visionary and AMA founder, Dr. Nathan Smith Davis, who wrote in 1855:

"Of all the voluntary social organizations in our country, none are at this time in a position to exert a wider or more permanent influence over the temporal interests of our country than the American Medical Association. This assertion may startle the mind of the professional reader and call forth a smile of incredulity, nay of contempt, from the nonprofessional; but let both patiently follow me to the end and then judge. I am aware that the details on which I am about to enter may appear to some unimportant, to others tedious and, to all of the present generation, wanting in novelty and interest; but they will appear far otherwise to those who shall come after us and live when time shall have thrown his dimming veil over all the doings of our day." (Quoted from the *History of the American Medical Association*—Fishbein, page 21.)

The Council on Private Practice of the House of Delegates of the American Medical Association must become a reality. The full and active support of all concerned doctors of medicine in making the Council a reality is earnestly solicited.

AMA Establishes Committee on Long Range Planning and Development

Ohio played a leading role in action of the AMA House of Delegates in regard to establishment of a Committee on Long Range Planning and Development.

Dr. John H. Budd, Cleveland, was a member of the committee which developed and presented the majority report on Planning and Development. He offered in addition a minority report which, upon motion of the Ohio Delegation, received the same status and handling as the majority report (known as the Himler Report after Dr. George Himler, of New York, chairman of the committee).

After considerable reference committee and House floor debate on the report of the Committee on Planning and Development (both the majority and minority reports), the House voted:

(1) To establish an ad hoc Committee on Long Range Planning and Development. Its membership is nine, appointed as follows: one from the Board of Trustees; five from the House; one from the Student AMA; and two from the AMA membership at large.

The ad hoc committee will receive the majority and minority reports, all reviews and correspondence on the subject and the transcript of the proceedings of the reference committee that considered both reports. It will study and make recommendations concerning the structuring of and the charge to a permanent Committee on Long Range Planning and Development and report those recommendations to the House at the 1970 Annual Convention.

(2) To send the majority and minority reports "to the component state societies for such specific action by their governing bodies as they deem warranted, it being understood that the resolutions so generated and all recommendations made in the reports (majority and minority) will be considered by the appropriate reference committees at the Annual Convention of 1970."

The Majority Report of the Committee on Planning and Development covers some 60 typewritten pages, offers 18 groups of recommendations totaling 57 in number. The Minority Report

offers 19 recommendations and suggests that this is only a partial list.

Dr. Budd, in commenting on the reports, said that numerous spokesmen during hearings pointed out items and statements objectionable in the Majority Report, and that most of these points were brought out in the Minority Report. Some of the objections were in the basic tone of the Majority Report . . . "notably the air of apology and selfdenunciation which pervades some of the Report" . . . and "assuming responsibilities for conditions which appear well beyond the influence and control of AMA is to invite more criticism of the medical profession when their impossibility of attainment becomes evident."

The Minority Report, however, makes it clear that it is an addendum to the Majority Report. "My purpose is not to destroy a comprehensive document of good intent, or to malign a committee on which it was my privilege to serve. My criticisms are intended to be constructive."

"There is merit in much of the Report's commentary, and in many of its analyses and recommendations. To point out just a few, the depiction of the present social and political climate . . . exposition of the varying non-medical reasons for poor health of the under-privileged . . . and evaluation of delivery systems of health care, including closed panel groups, are perceptive, relevant and accurate.

"The document deserves fair hearing and calm judgment. . . ."

On Prolonging Debate

An Ohio resolution (AMA Resolution 11) proposed that the Council on Constitution and Bylaws, when directed to formulate language for a Constitution and Bylaws change adopted by the House of Delegates, restrict its function to this duty only, and not editorialize in its report on the wisdom of policy change, or reintroduce the subject for debate.

The resolve paragraphs of the Ohio resolution read as follows:

Resolved, That bylaw amendments prepared by the Council on Constitution and Bylaws in response to direction of the House of Delegates be acted upon by the House of Delegates sitting as a committee of the whole; and be it further

Resolved, That discussion of constitutional or bylaw changes brought to the floor of the House of Delegates under such circumstances be restricted by the Speaker to propose modification of wording, but not of intent, for purpose of clarity.

The resolution was defeated on recommendation of the reference committee. An Ohio spokesman expressed the belief that the concept of the resolution has merit. It was rejected primarily because of an interpretation of limiting free debate. On the contrary, it would deal only with matters already debated and decided by the House.

Other Actions at Denver Meeting

In all, the House of Delegates considered 99 items of business: 22 reports from the Board of Trustees; three special reports; one from the Council on Constitution and Bylaws; five from the Council on Medical Education; two from the Council on Medical Service; and 66 resolutions (five of which were memorials).

The House adopted a comprehensive statement of policy in regard to health care for the poor.

"It is a basic right of every citizen to have available to him adequate health care; it is a basic right of every citizen to have a free choice of physician and institution . . .; the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.

"The medical profession must take the leadership and actively support constructive community efforts to eliminate those conditions that adversely affect health.

"The health problems of the poor are basically community health problems, and . . . programs must be adapted to local needs.

"Health care for the poor should not be disassociated from but rather should be a vital part of, the overall health care system . . ."

The House adopted a strong policy statement on marihuana which in part stated: "Cannabis (marihuana) is a dangerous drug and as such is a public health concern. It is a psychoactive substance which can have a marked deleterious effect on indivdual performance and social productivity. A significant number of exposed persons become chronic user with concomitant medical and interpersonal problems. The sale and possession of marihuana should not be legalized. . ."

Expressed its "firm opposition to on-site auditing in physicians' offices of tax-supported programs by representatives of governmental agencies" and urged that problems between physicians and intermediaries or between physicians and

governmental agencies be referred to local peer review committees.

Expressing deep concern about the ever-increasing costs of hospital care services, the House resolved that the "AMA Board of Trustees request the Board of Trustees of the American Hospital Association to join with it in urging hospital boards and hospital medical staffs to develop and institute cost control measures for hospital care services."

The House also resolved that it "reaffirms its endorsement of the tax credit plan and urges the Board of Trustees to give this plan the strongest support and the widest publicity among members of the Association and the public." In addition, it urged AMA councils and committees to intensify efforts "to develop other realistic and effective plans of medical care coverage available for all persons in the United States, utilizing multiple methods of financing and free choice of mechanism based on adequate standards of coverage."

At the same time, the House urged all state medical associations to "submit promptly any other realistic proposals which they believe should be developed as AMA proposals for effective, widely available medical care insurance or prepayment plans."

Also in connection with cost, the House recognized that "various news media and agencies of the federal government routinely blame the medical profession for the rising cost of health care; and . . . some physicians and even the publications of the American Medical Association . . . use the erroneous expression health care when they should use the correct term medical care." The House resolved that "the Board of Trustees . . . initiate, promptly, remedial measures to clarify the meaning of the expressions 'medical care' and 'health care' and to assure their correct usage in all official publications of the American Medical Association" and that the executive vice-president design activities "to correct the terminology of the lay press and enlighten the understanding of the public."

Dr. Millis Honored

John S. Millis, Ph.D., former chancellor of Western Reserve University, is the ninth recipient of AMA's "Layman's Citation for Distinguished Service."

The award, approved unanimously by the House of Delegates in Denver, is given for "unusual contribution by a layman toward advancement of the ideals of American medicine in the fields of medical science, medical education, or medical care."

Born in Palo Alto, Calif., he received his bachelor's, master's and doctor's degrees from the University of Chicago. He is a former dean of administration at Lawrence College, and prior to joining Western Reserve, was president of the University of Vermont for eight years.

Dr. Millis served as chairman of AMA's Citizens Commission on Graduate Medical Education, which produced the "Millis Report." He has been a member of numerous other national bodies, including the National League for Nursing, the National Conference of Christians and Jews, and the Carnegie Foundation for the Advancement of Teaching.

Dr. Millis will receive the award during the AMA Annual Convention in Chicago next June.

A number of Ohio physicians participated in Scientific Sessions, presented exhibits, or took part in other activities at the AMA Clinical Convention in Denver, as shown in the official programs and other publications issued by the AMA.

Thomas E. Shaffer, of Columbus (featured on the cover), presided at the 11th National Conference on the Medical Aspects of Sports, held on November 30. Dr. Shaffer is chairman of the AMA Committee on Medical Aspects of Sports, and is a member from the OSMA on the Ohio Joint Advisory Committee on Athletic Injuries.

Dr. James L. Henry, Grove City, discussed "Hospital Utilization Review," before the Medical Services Conference sponsored by the AMA Council on Medical Services. Dr. Henry is chairman of the Utilization Review Committee of the Academy of Medicine of Columbus, and his talk (see page 170) discusses progress being made in central Ohio. Dr. Henry is also Treasurer of the OSMA.

ROLE OF THE COUNTY MEDICAL SOCIETY IN

Hospital Utilization Review

By James L. Henry, M.D., Columbus

UTILIZATION REVIEW has gained a degree of prominence and importance because of the mandate of Medicare. Utilization review, in a sense then, has been condemned by association. One cannot criticize the logic that creates such a condemnation, however, since utilization review programs preceded Medicare by a number of years.

In 1960, the Board of Trustees of the AMA stated, "Evaluate the quality of medical care on the basis of documented evidence to support diagnosis, treatment, and justified utilization of hospital facilities." And in 1964, the House of Delegates of the AMA adopted the following concepts: "Consumers, third party payors, and government regulatory agencies have established interests in mechanisms for the financing of medical care, but the medical profession should bear the major responsibility for reviewing and 'policing' utilization and quality controls. Inasmuch as the judicious use of hospital facilities by the public and physicians is essential to the efficient and economic functioning of the prepayment and voluntary health insurance systems, the several medical societies should urge and assist the medical staffs of hospitals to form hospital utilization committees."

One more item of action at the AMA level that emphasizes the importance of utilization review and establishes the function of a review committee, namely, "Review of hospital admissions with respect to need for admission, length of stay, discharge practices and evaluation of services ordered and provided." This statement is from the Joint Commission on Accreditation Bulletin No. 40. The Board of Trustees of the AMA, in 1966, stated, "It is the Board's present position that physicians can best serve the interest of their patients and their profession by accepting, when called upon, membership on utilization review committees that carry out the functions prescribed in the (Medicare) law, and conducting such functions with complete professional objectivity and independence."

The Council on Medical Service points out that extended care cases must be reviewed within seven days after the stay becomes extended. This, then, requires weekly reviews by the utilization review committee or a component thereof.

AMA Board Action

As the AMA Board of Trustees stated at the 1969 Annual Convention,

"The physician's influence on the costs of health care will be in proportion to his conscious efforts to adhere to practices which conserve the resources of his patient, his involvement in community responsibilities and the structures of sources of financing, his acceptance of appointment on essential boards and committees, and his informed cooperation with hospitals and other institutions and community agencies in the health care field.

"As the provider of medical service, the doctor has a significant and responsible role in any organized effort to control health care expenditures.

"In this role, the physician has a challenge to maintain and improve a system that best serves the public and is most acceptable to him and to the profession of which he is a part. He should seek, unselfishly, to discharge these obligations."

All of these references agree that utilization review is a good idea. It proves the integrity, skill, and responsibility of the medical profession. Review should be done for the patient and the profession and, incidentally, for the third party, but the third party is never to be construed as the primary purpose for utilization review.

Columbus Academy Makes Progress

The following is what one medical society—the Columbus, Ohio, Academy of Medicine—has accomplished to date and the methods that have been employed and the projects that are in the mill. It is impossible to call the following a hospital program because it is, in reality, an inte-

Dr. Henry is chairman of the Utilization Review Committee for the Academy of Medicine of Columbus and Franklin County. This article is the text of a lecture prepared for presentation before the 1969 Medical Services Conference sponsored by the Council on Medical Services of the American Medical Association, November 29 at Denver, in association with the AMA Clinical Convention. Dr. Henry is also Treasurer of the Ohio State Medical Association.

grated program of utilization review conducted by physicians at several different levels and degrees of involvement.

The medical society, in anticipation of Medicare, decided that it must create a utilization review committee to educate, advise, assist, supervise, and hear inquiries from the several hospital and extended care facility (ECF) committees that would be activated under the law. The society committee was and is the professional leadership for physicians in the scope of utilization and is arbitrator for intermediary claim consideration. All other committees are then primarily concerned with professional judgments.

The medical society utilization review committee is chaired by a physician appointed by the society president, and the committee membership consists of the chairmen of the several acute hospital utilization review committees. The chairman of the utilization committee of the local osteopathic hospital has been assigned a voting membership on the society committee. The reasons for this are both apparent and devious, but, albeit, effective.

To be a bit repetitive, the mechanics of establishing the membership of the Academy's utilization review committee provides that the chairman of a given hospital's utilization committee is submitted by the hospital administrator for membership. If he qualifies and is acceptable to the medical society, this physician is then appointed to the society's utilization committee. If a proposed member is not acceptable to the medical society, the hospital administrator is so notified and an acceptable replacement is requested. This device permits the local medical society to have direct supervision of the several hospital committees and is a direct, unencumbered avenue for the appraisal of both the method and effectiveness of several approaches to utilization review.

The official policies of the medical society are thereby transmitted to the several hospital committees and the programs of utilization review are relatively consistent, uniform, and oriented to the aims of medicine and the best interests of the patient.

Emphasis on Action

It's well and good for a medical society to state dogmatically that it is the fountainhead of knowledge and answers concerning utilization review for all who may be troubled. This posture is accompanied by certain basic requirements, however, like produce or get off the pot or don't shoot blanks. Concrete evidence of sincerity and intention was demanded. Concrete action that would demonstrate that the medical society could and would defend its legal right to conduct and supervise utilization review programs. After many meetings, subcommittees, and conferences with physicians, providers, and intermediaries an acceptable program was developed and published for the education of all concerned. These guidelines provide a point of judgment in matters professional and administrative alike. This patience and perseverance demonstrated to one and all the concern, integrity, and sincerity of physicians to accept leadership in utilization review programs.

Some of the points that have been wrested and at least fought to a draw are:

Hospital and ECF utilization committees are responsible for professional judgments. The administrative problems rest with the medical society. The society committee will consider any problem case regardless of who the initiator may be—patient, physician, intermediary or provider, equally.

The initiator of action should be unimportant; the important factor must be that proper, impartial, unbiased consideration is employed in arriving at a decision. When all concerned can accept this as a result of performance, then peer review is both professional and rewarding. A refusal to consider a case can create harmful suspicion and doubt.

Method of establishing a professional base for determination of extended stay: After carefully reviewing all of the programs, it became apparent that the most meaningful and scientific approach is the length of stay by disease entities, and this method should be applied to all patients.

By applying review to all patients, it is a professional, scientific instrument of physicians and not the work of government functionaries, as one physician, sardonically stated.

Some Ground Rules

The Committee feels strongly that erelong the several federal agencies will arrive logically at the length of stay, with justified overstay concept. Self preservation seemed to dictate that physicians would be served best by serving themselves with the creation of lengths of stays.

Locally developed lengths of stay reflect the local penchants and peculiarities of medical practice. These may not be considered in a federally conceived program that is not tailored to a given region's nuances and techniques. Length of stay documentation and justification demands more information be supplied for evaluation and equally important, more often.

In context, the medical society has published lengths of stay for evaluation of ECF patients

and is in the process of preparing guidelines for the lengths of stay by disease entity for acute hospital patients. The data collection is being done by the local Blue Cross Plan and is from all discharges regardless of age, as was noted the committee believes that proper impartial review should be applied to all patients. Utilization review for patient-recipients only is inconsistent with good medical practice, plus a detractor might construe that varying levels of care exist. This could be an admission that the federal government had caused the upgrading of medical care. This would be hard to accept.

Records Important

Evaluation of existing programs demonstrated that 30-day extended stay programs were not adequate nor desirable. These programs were the ones most queried by the intermediaries, and the medical records reviewed from a 30-day program were more sketchy, incomplete, and improperly documented than those reviewed from hospitals requiring seven day justification.

Inadequate medical records are a disgrace, a disservice to one and all, and a cause for denial of claims by the intermediary. Properly documented medical records are almost without exception, the perfect ensurer to all inquiries and criticisms. It is apparent that the length of stay method of utilization results in greatly improved medical records.

Blue Cross Guidelines

The guidelines published by Blue Cross for the medical societies include the following which may well be what this is all about:

"The Utilization Review Committee has several responsibilities to discharge including advisory duties to the provider, ensuring that quality medical care is being afforded the patients, and determining that the facility is being properly and efficiently utilized. A most important function of this committee is the professional determination of the level of care and the necessity of such care being given to a patient-recipient. The Utilization Committee does not make the final determination of whether or not the claim is qualified for Medicare benefits. In conjunction with the attending physician, the Committee determines the medical necessity for and the level of care being given and reviews the need for continuing care.

"The Utilization Review Committee is expected to express an opinion on whether the care being given to a patient can be qualified as skilled and needed. Both of these factors must apply in order to qualify the patient for covered care. The Utilization Review Committee must concern itself with 'skilled and necessary,' for the Committee is not directly responsible for the approval or denial of Medicare benefit claims. The covered or non-covered decision is the ultimate responsibility of the intermediary's medical staff.

"An action of the Utilization Review Committee that declares the care to be less than skilled or needed is a medical determination and only indirectly places the Committee in the position of judging that the care is non-covered.

"Although the Committee does not make a direct administrative determination of the covered or non-covered status of the claim, its professional opinion has merit, weight and influence upon the final determination that must be made by the intermediary. In order to facilitate and correlate benefit claims, the Utilization Review Committee should forward to the intermediary its opinion and, whenever practical, the concise medical information that served as the basis for such an opinion. Abbreviated terms such as 'covered' or 'continued stay' should be avoided as expressions of the action of the Committee inasmuch as they are indefinite, non-explanatory, and confusing and can reflect an incorrect or inaccurate intent.

"The Utilization Review Committee has a medical function and responsibility in that it must determine the level of care, the necessity for such care, and the propriety of the stay of the patient-beneficiary in the Extended Care Facility."

Clevelander Heads American School Health Association

Carl G. Opaskar, M.D., director of School Health Services, Cleveland Public Schools, has been elected President of the American School Health Association.

Dr. Opaskar, a native of Cleveland, was in the private practice of Medicine in Cleveland from 1939 until 1959, when he assumed his present post with the Cleveland Public Schools. He is a member of the Committee on School Health of the Ohio State Medical Association.

As President of the ASHA, Dr. Opaskar will serve during the coming year as the Association's highest elected officer. The ASHA (formerly the American Association of School Physicians) is comprised of 20,000 members and has its national headquarters in Kent, Ohio. It is unique among professional organization in the United States in that it is devoted solely to school health. The official publication of the ASHA is *The Journal of School Health.*

Proceedings of The Council...

Minutes of the December 13-14 Meeting in Columbus; Approval of the 1970 Budget Is Among Actions Taken

A REGULAR MEETING of The Council of the Ohio State Medical Association was held Saturday and Sunday, December 13 and December 14, 1969, in the headquarters office, Columbus. Those present on Saturday, December 13, were: All members of the Council except Dr. Dwight L. Becker, Lima, Councilor of the Third District. Others in attendance were: Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. James S. Imboden, Columbus, AMA Field Representative; Dr. John H. Budd, Cleveland, chairman of the Ohio delegation to the AMA; Messrs. Page, Edgar, Gillen, Campbell, Clinger, Price, and Moore of the OSMA headquarters office staff. Those present on Sunday, December 14, were: All members of The Council except Dr. Dwight L. Becker, Lima, Councilor of the Third District, and Dr. James C. McLarnan, Mt. Vernon, Councilor of the Tenth District. Others in attendance were: Mr. Stichter, Mr. Imboden, Dr. Budd, and the following members of the OSMA executive staff: Messrs. Page, Edgar, Gillen, Campbell, Clinger, Price, and Moore.

Announcements

The President announced that the next meeting will be held in February and the deans of Ohio's medical schools will be invited to attend.

Minutes Approved

Minutes of the meeting held October 4-5 were approved by official action.

Reports by Councilors

The Councilors reported on organizational activities in their districts.

It was announced that the Sixth District Meeting and the Sixth District Postgraduate Day would be reinstituted and that additional public relations activity would be implemented in that area.

The Councilor of the Seventh District brought up a problem in that district resulting from a ruling of the Joint Commission on Accreditation of Hospitals disallowing the acceptance of history and physical examinations by foreign externs and countersigned by members of the medical staff.

Report by Ohio Director of Health

Dr. Emmett W. Arnold, Columbus, Ohio Director of Health, addressed the Council with regard to the current status of public health in Ohio.

Fluoridation

Dr. Arnold discussed the adoption by the legislature of mandatory fluoridation legislation and acknowledged the "fine cooperation" of the Ohio State Medical Association in obtaining passage of this law.

Rubella

The director discussed the new legislation requiring rubella immunization for "school enterers." He expressed the opinion that rubella immunization should be "initiated and carried through for all children below adolescent age."

California Encephalitis

Dr. Arnold told of a severe mosquito population build-up in nine counties in northeastern Ohio during the past summer and told of the department's mosquito eradication campaign. Thus far, 24 cases of California encephalitis have been diagnosed and 17 are presumptive.

Tuberculosis

He pointed out that the death rate is down for tuberculosis; that there are more hospital beds than needed for this disease; and that such beds should be made available for other uses.

Nursing Homes

Dr. Arnold said that 1,162 nursing homes with 47,944 beds are currently licensed.

Solid Waste Laws

In the category of solid waste laws, 604 landfills and 24 incinerators are licensed.

Water Pollution Control

Dr. Arnold said there are 102 projects under way and that there is a need for $460 million to

bring the program to a desirable level. Quality standards for water have been set.

Air Pollution

Hearings are being held on air qualification standards.

Health Clinics for Migrant Laborers

Health clinics for migrant laborers have been established and 10,000 patient visits have been recorded. Government support for this activity will be available for sometime to come, according to the director.

Hospital Licensure

The director told the Council that the Ohio Public Health Council had asked him to discuss with the Ohio State Medical Association, hospital licensing legislation for consideration by the 1971 Ohio Legislature.

Drug Abuse Problem

On **motion** by Dr. Clarke, the Council **adopted** the following statement with regard to the drug abuse problem:

> "In view of our continuing concern with regard to the drug abuse problem, the Governor of Ohio and the Ohio Director of Health are herewith requested to establish a drug abuse program within the Ohio Department of Health to combat the drug abuse problem."

Membership

Statistics

The Executive Secretary provided Council with membership statistics which indicated slight gains in OSMA and AMA membership. OSMA membership as of December 10, 1969, was 10,232, compared with a total membership of 10,153 on December 10, 1968. Of the 10,232 members, 8,786 were affiliated with the American Medical Association.

Financial Report

The Council recessed and reconvened in executive session for the presentation of the annual budget for 1970 by Dr. P. John Robechek, Cleveland, chairman of the Auditing and Appropriations Committee.

The report of the committee, including a budget for 1970, **was approved** by official action:

1970 Budget

The Ohio State Medical Journal	$ 37,500.00
Executive Salaries	112,000.00
Executive Staff Expenses	15,500.00
Secretarial, Administrative, Clerical, Military Advisory Chairman, Salaries	79,150.00
President: Expense $6,000; Honorarium $4,000	10,000.00
President-Elect: Expense $3,600; Honorarium $2,000	5,600.00
Council Expense	15,500.00
AMA Delegates-Alternates Expense (Per diem $35; Ground travel $20)	16,000.00
Committees:	
Auditing and Appropriations (bookkeeping service and audits)	4,000.00
Cancer	350.00
Disaster Medical Care	500.00
Education	2,500.00
Environmental and Public Health	1,000.00
Eye Care	300.00
Government Medical Care Programs	2,500.00
Hospital Relations	1,850.00
Insurance	750.00
Judicial and Professional Relations	600.00
Laboratory Medicine	500.00
Maternal Health	2,000.00
Medicine and Religion	200.00
Membership and Planning	10,000.00
Mental Health	2,750.00
Nursing	400.00
Private Practice	2,500.00
Public Relations and Economics	400.00
Rural Health	1,200.00
School Health	3,000.00
Scientific Work	500.00
Workmen's Compensation	250.00
Annual Meeting	55,000.00
Conference of County Society Officers	2,000.00
Councilor District Conferences (Speakers' Seminars)	5,000.00
Department of Economic Research (Materials and Projects)	2,500.00
Equipment Rental (Xerox and Postage Meter)	6,000.00
Emergency Fund	2,500.00
Family Practice Scholarships	4,000.00
Insurance and Bonding	5,000.00
Lectures for Medical Students	4,500.00
Legal Expense	25,000.00
Library (Subscriptions and books for general use)	400.00
OSMAgram	7,500.00
Postage	8,500.00
Professional Relations Activities (Medicare Newsletter; AMERFund)	7,500.00
Public Relations Department: Information Materials	3,000.00
Public Relations Department: Miscellaneous Activities (Gongwer and legis. sub., reports; Com. on Legis.; A. Soc. Econ. Conf.)	7,500.00
Rent	21,465.00
Stationery, Printing, Supplies	10,000.00
Taxes: Payroll	8,500.00
Telephone and Telegraph	8,500.00
Furniture and Equipment	10,000.00
TOTAL	$533,665.00

The executive session was adjourned and the Council reconvened in regular session.

By official action, the minutes of the December 12, 1969 meeting of the Auditing and Appropriations Committee **were approved,** as were each of the recommendations contained therein. The 1970 budget **was approved.**

Resolutions Regarding OSMA Employee Pension Trust Agreement

The following resolutions, in connection with the Ohio State Medical Association Employee Pension Trust Agreement, **were adopted** by the unanimous consent of members of the Coucil present at this meeting:

RESOLVED, That this Association adopt the pension plan and enter into the trust agreement contained in the Amended Ohio State Medical Association Employee Pension Trust Agreement effective as of December 31, 1969 in the form presented to this meeting or with such amendments as in the opinion of general counsel and the actuarial consultants may be found necessary to meet requirements for qualifications of the plan and trust under Sections 401 and 501 of the United States Internal Revenue Code; and

RESOLVED FURTHER, That the Executive Secretary of this Association be, and he hereby is, authorized and empowered to execute and deliver said plan and trust agreement to the trustee hereof; that the Treasurer be, and he hereby is, authorized and directed to transfer to the trustee funds of the Association appropriated to the funding of this plan on or before December 31, 1969 and that the officers, general counsel and the actuarial consultants be, and they hereby are, individually authorized each to take appropriate action to submit said plan and trust agreement for a determination of the Internal Revenue Service that said plan meets the requirements of Section 401 of the Internal Revenue Code for the deferral of income tax liabilities to the employees and that said trust meets the requirements of Section 501 for exemption from income taxes of its earnings; and

RESOLVED FURTHER, That the officers of this Association or any of them is hereby authorized and directed to secure such consent and agreement of any employee, former employee, beneficiary, trustee, insurer or other person, firm or corporation which in the opinion of general counsel is necessary or desirable in order to accomplish the consolidation of former pension plans or agreements of the Association and the assets of any predecessor trust or trusts into said Amended Plan and Pension Trust.

The President appointed, and the Council **approved,** the following Pension Committee: Dr. James L. Henry, chairman, Dr. William R. Schultz, and Mr. Hart F. Page.

By official action, the Council **adopted** the following resolution:

Employee Group Life Insurance

RESOLVED, That the proposal of the Pension Committee with respect to a group life insurance program for the employees of the Association be approved and that the Treasurer be, and he hereby is, authorized to procure such group policy as he determines suitable, on competitive quotations from responsible insurers, to provide such benefits, not to exceed in face amount of insurance 2½ times the annual salary of any employee or the sum of $75,000, whichever is the lesser, as may be obtained with the funds allocated and budgeted for such purpose; and that he be, and hereby is, authorized to make such premium prepayments as he shall consider expedient, having regard for the premium discounts offered and available funds.

Amendments to Constitutions and Bylaws of County Societies

Ashland County

The Council discussed the proposed amendment to the bylaws of the Ashland County Medical Society and instructed the Executive Secretary to obtain additional information from the society with regard to the amendment and its purpose.

Lake County

An amendment from the Lake County Medical Society involving a raise in the society's dues **was approved,** subject to proper drafting of the amendment as suggested by the OSMA legal counsel.

Lucas County

Revisions in the constitution and bylaws of the Academy of Medicine of Toledo and Lucas County **were approved,** subject to changes suggested by the OSMA legal counsel.

American Medical Association

Clinical Convention

Dr. Budd reported on the clinical convention of the AMA House of Delegates held November

30-December 3, 1969, in Denver, Colorado. He indicated that there were 61 resolutions considered by the House and that Ohio was represented by nine delegates and six alternate-delegates plus the president, president-elect, the treasurer, and Dr. Schultz.

Dr. Budd indicated that Resolution No. 11 from Ohio, clarifying the duties of the AMA Council on Constitution and Bylaws, failed, probably due to a misunderstanding on the part of the House as to its purpose and objectives.

Dr. Budd reported that the Committee on Private Practice requested by an Ohio resolution, was established within the Council on Medical Service of the AMA.

Long-Range Planning Report

The Ohio delegation was successful in obtaining the same status for the John H. Budd minority report on long-range planning as the Himler report of the long-range planning committee. A new long-range planning committee was called for and an ad hoc committee was established to serve as archivist for the Himler and Budd reports, and to give the permanent committee operational guidelines. Various sections of the Himler and Budd reports will be considered at the June meeting of the AMA.

Candidates for AMA Committees

The Council **approved** the candidacy of Dr. Donald V. Walz, Mt. Vernon, for the AMA Committee on Blood, and Dr. Henry A. Crawford, Cleveland, for the Council on National Security of the American Medical Association.

County Society Officers Conference

The President announced that the County Society Officers Conference for 1970 will be held March 22 at the Fort Hayes Hotel.

Federal Legislation

Tax Reform Bill

Dr. Smith reported on the Ohio State Medical Association and American Medical Association efforts which were a part of the successful endeavor to remove from the tax reform bill a section which had been inserted by the Senate Finance Committee to reduce deferred compensation for professional corporations to the Keogh level, $2500 per year or 10 percent of income, whichever is the lesser.

The Council was advised that Dr. Smith and Mr. Page visited with Senator Saxbe and Representative Jack Betts, Ohio Congressmen on the House Ways and Means Committee in Washington, November 24. Conversations with Senator Saxbe following that date were related to the Council.

Dr. Smith indicated that the present thinking in Washington is that the Treasury Department next year will push for some type of equality for the self-employed professions as related to employees of corporations with regard to deferred compensation tax treatment.

Other Federal Legislation

Mr. Edgar reported on other Federal proposals, including a bill by Congressman Clarence Brown, Jr., of Ohio, to establish a separate Department of Health in the Federal Government. By official action, the Council voted to **endorse** Congressman Brown's bill.

By official action, the Council voted to **support** legislative efforts in Congress to remove chiropractic care from medicaid.

Mr. Edgar alerted the Council to the fact that this Association will be required to be even more active in Federal legislation next year.

State Legislation

Mr. Page reported on pending state legislation.

Judicial Merit Selection Plan

Council voted to **support** House Joint Resolution No. 27 involving the judicial merit selection plan.

Prescribing Intoxicating Liquors

The Council **approved,** in principle, a proposal by Representative Charles Fry, involving repeal of certain sections of the law with regard to prescribing intoxicating liquors.

Members of a Union

The Council voted to request exemption for professionals in pending legislation which might require employees of political subdivisions to become members of a union.

Medicaid Hearings

Dr. Smith reported on medicaid hearings before the Pottenger committee in the Ohio Legislature, at which hearings he appeared as a witness for the Ohio State Medical Association.

Malpractice Suits

Dr. Smith reported on discussions with Representative William G. Batchelder, Medina, with

regard to the introduction of legislation to relieve the problem of nuisance malpractice suits.

Ohio Medical Indemnity, Inc.

By official action, the Council authorized President Smith to appoint a nominating committee to select nominees for the Ohio Medical Indemnity, Inc., Board of Directors, such nominees to be voted on at the annual OMI stockholders' meeting in April, 1970. Dr. Smith named: Dr. Theodore L. Light, Dayton, chairman; Dr. Paul N. Ivins, Hamilton; and Dr. William M. Wells, Newark.

The Council discussed a letter from Dr. Ben Arnoff, chairman of the Professional Relations Committee of the Academy of Medicine of Columbus and Franklin County, with regard to the method of referral of Ohio Medical Indemnity cases to county medical society review committees.

The Executive Secretary was instructed to bring to the attention of Ohio Medical Indemnity, Inc., the policy adopted by the Council on January 25 and 26, 1969, covering all fee review by third parties.

Workmen's Compensation

Mr. Campbell reported on 186 Bureau of Workmen's Compensation cases occurring from October, 1965 to December, 1969, and the disposition thereof.

Committee Reports

Auditing and Appropriations

Mr. Page presented the minutes of a meeting of the Auditing and Appropriations Committee held September 3, 1969. Approval of these minutes included the **approval** of a telephone credit card policy for the Ohio State Medical Association.

The minutes of the committee with regard to the possibility of supplying secretarial services to Ohio specialty society organizations were amended to authorize the exploration of the feasibility of a pilot program in this area involving the Ohio Chapter of the American Academy of Pediatrics.

Education

Minutes of the November 5 meeting of the Committee on Education were presented by Mr. Edgar. The establishment of an Ohio State Medical Association Commission on Education was **approved.**

The question with regard to "physicians' assistants," which originated with Amended Resolution 13 at the 1969 OSMA House of Delegates, was referred to the Commission on Education.

The commission was authorized to invite, at OSMA expense, certain out-of-state experts to assist with the work of the commission.

The Council asked delay on the recommendation of the committee that Council provide a recognition certificate for those members receiving the AMA continuing medical education award. Council agreed that a letter of congratulations should be sent to those receiving the award.

Public Relations and Economics

Mr. Edgar presented the minutes of a meeting of the Committee on Public Relations and Economics held October 22, 1969.

It was announced that the committee's recommendations that its name be changed from the Committee on Public Relations and Economics to the Committee on Public Relations and that there be certain changes in its mission are parts of the proposed revision of the OSMA Constitution and Bylaws which will be considered by the House of Delegates in May.

A resolution on "Medical Spokesmen" was referred back to the committee for clarification and a restatement with a recommendation that spokesmen be identified as speaking for their county medical societies.

The committee's recommendations with regard to establishing top priority public relations activity of the Association in the fields of drug abuse, air and water pollution were approved.

Private Practice

Minutes of a meeting of the Council on Private Practice, held November 9, 1969, were presented by Dr. Lieber.

The Council voted to amend the proposed statement on tenure and structure suggested by the Council on Private Practice to establish a Committee on Private Practice as a special committee of the Association to be appointed by the President with the consent of Council of the Association. The amended statement of Council of OSMA reads as follows:

Tenure of Committee

The committee next discussed the organization, goals and tenure of its membership. The committee voted unanimously to recommend that the committee be comprised of seven members, with each member appointed to terms of three years, and that terms of appointment be so set that two members be appointed each

year by the President, except in each third year three members shall be appointed.

The committee's proposed definition of private practice was returned to the committee for revision. The clause relating to the functions of the committee was amended by the addition of a paragraph to read as follows:

"2. To encourage development of new methods of delivery of medical services within the private practice sector where such methods will lead to better and more efficient care."

Laboratory Medicine

Mr. Campbell presented the minutes of the November 19 meeting of the Committee on Laboratory Medicine. Approval of the minutes included **approval** of the resubmission of Senate Bill 268 (1969) on the subject of laboratory licensure, if such introduction becomes necessary.

Medicine and Religion

Mr. Campbell presented the minutes of a meeting of the Committee on Medicine and Religion held December 10, 1969.

Approval by the Council of the minutes included the **approval** of a recommendation of the committee to explore the possibility of establishing a standard uniform identification card for the clergy for use in making hospital calls.

In addition, Council **approved** the committee's recommendation that the Committee on Rural Health consider the advisability of including a speaker on medicine and religion on the junior medical student lecture program.

School Health

Mr. Clinger reported on the October 22 meeting of the Committee on School Health. Approval of these minutes included the **approval** of the recommendation of the committee that there be established a Joint Advisory Committee on Special Education of the Ohio State Medical Association and the Ohio Department of Education.

Cancer

Mr. Clinger presented the minutes of the Ohio Cancer Coordinating Committee, Inc., and Cancer Task Force meeting of October 1, 1969. The minutes were accepted for information.

Title XIX

Mr. Gillen presented minutes of the October 29 meeting of the Title XIX Subcommittee.

Council **approved** the committee's recommendation that the OSMA reaffirm its previous policy calling for physicians to bill for their services on their own letterhead or bill head. Previous Council action on this was December 12, 1966.

With regard to a letter sent by the Ohio Department of Public Welfare, requesting from a physician a list of representative operations and the range of related charges to private patients in their practice, the Council **approved** the committee's opinion that the individual physician should make his own determination as to whether or not he wishes to provide this information to the Ohio Department of Public Welfare.

Hospital Relations

Mr. Gillen presented the minutes of a meeting of the program planning committee for the Fourth Ohio Conference for Medical Chiefs of Staff held October 29, 1969. The minutes and the accompanying program for the 1970 conference **were approved.**

Membership and Planning

Minutes of the November 19 meeting of the Membership and Planning Committee were presented by Dr. Schultz. The minutes were received for information.

Dr. Schultz distributed the proposed membership survey form to the Council for study. The survey form **was approved,** in principle, by the Council.

Revision of OSMA Constitution and Bylaws

Dr. Fulton reported on meetings of this committee held November 9, November 14 and November 23. He announced that the revision of the Constitution and Bylaws is in draft form and would be submitted for final consideration by the Council at the February meeting.

Computer Coding for Third Party Billing

Mr. Page discussed efforts to obtain a standard coding system for computer billing with regard to medical procedures. He indicated that the House of Delegates had instructed the AMA staff to proceed without delay with the establishment of one standard billing code.

Rubella Immunization

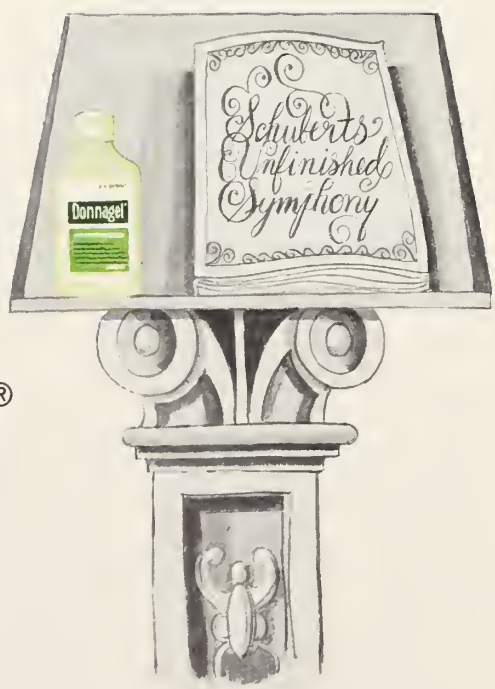
A communication from Dr. Elizabeth R. Aplin, Medical Director, Bureau of Crippled Children Services, Ohio Department of Public Welfare, with regard to a rubella immunization program, was referred to the Committee on School



The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can at the most inopportune time, it takes a comprehensive agent to treat the diarrheal syndrome and help get the patient back on the job. That's why many physicians rely on Donnagel, especially during the fall and winter months when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. It also contains the belladonna alkaloids to calm GI hypermotility and help relieve the distressing discomforts which so often accompany diarrhea. Certainly it's less expensive and more convenient than taking two medications. And the dosage is lower too. Available in the handy 4-oz. plastic bottle at pharmacies everywhere on your prescription or recommendation.



Diarrhea and its Discomforts

Donnagel®

Each fluid ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.[illegible] mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Methyl paraben benzoate (preservative), 60 mg.; Alcohol, 3.8%.

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THERE'S A ROBITUSSIN FOR EVERY COUGHING NEED

All the Robitussins contain gylceryl guaiacolate, an outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
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Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
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Non-narcotic for 6-8 hr. cough control
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Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Dextromethorphan hydrobromide . . . . 15.0 mg.
Alcohol, 1.4%

For unproductive allergic coughs
ROBITUSSIN A-C®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Pheniramine maleate . . 7.5 mg.
Codeine phosphate . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Phenylephrine hydrochloride. . . . . 10.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"
COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate . . 50.0 mg.
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Use this handy guide to pick the right formulation for each coughing need

	Robitussin	Robitussin-DM	Robitussin A-C	Robitussin-PE	Cough Calmers
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●		●
Antihistamine			●		
Long-Acting (6-8 hours)		●			●
Nasal, Sinus Decongestant				●	
Non-narcotic	●	●		●	●

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Health, with a request that the committee develop recommendations for consideration of the Council.

Certification vs. Licensure

The following statement on certification vs. licensure from the Pennsylvania State Medical Society was presented to the Council for information. The Council referred the statement to the Committee on Education.

"In March, 1967, the Pennsylvania Medical Society Board established the position that the state society favored the licensing of paramedical personnel under the State Board of Medical Education and Licensure. The Pennsylvania Medical Society Board has reconsidered its position regarding the support of licensure of paramedical personnel in Pennsylvania and, at the recommendation of the Pennsylvania Medical Society Council on Education and Science, supports certification of paramedical personnel utilizing nationally recognized certification programs in place of licensure. The change of opinion was predicated on three primary concerns. Licensure in a mobile society does not provide for uniform interstate recognition. In our age of rapidly developing scientific and technological advances, there is a growing need for more highly specialized paramedical personnel. Licensure of new categories of manpower is not the answer to the issue. Such licensure could cause further fragmentation in use of personnel and might establish rigid job descriptions which would become obsolete as technology progresses and as patterns of delivery of medical care change. In supporting licensure instead of certification, there is an element of danger. The power of definition or designation of what constitutes the practice of any profession lies within the legislature (the lay public) and not the medical profession."

Award Plaques Approved

The Council approved award plaques, as submitted by the Executive Secretary, for AMA delegates and alternate-delegates, chairmen and members of standing committees, and chairmen of special committees, at the termination of their services to the Association in the categories named.

Cleveland Drug Abuse Seminar

Dr. Fulton reported on the drug abuse seminar sponsored by the Cleveland Academy of Medicine, November 3-5, 1969. The Council voted to commend the Cleveland Academy of Medicine and Dr. William V. Trowbridge on the excellence of the program and its successful operation.

Ribicoff Report

Summaries of the Ribicoff Report on "Medical Malpractice: The Patient vs. the Physician," pursuant to Senate Resolution 25, 91st Congress, and dated November 20, 1969, were distributed to the Council.

Department of Economic Research

A memorandum from the Department of Economic Research with regard to suggested functions and projects was presented by Mr. Price. The report was accepted as a guideline for the department at this time.

In answer to one of the questions proposed by Mr. Price, the Council rendered an opinion that it is proper for the department to accept funding by foundations and government grants for certain studies when such grants are approved by the Council.

The meeting then adjourned.

ATTEST: HART F. PAGE,
Executive Secretary

ON THE OMPAC FRONT

Good, But Not Quite Good Enough

A project which has been pushed by the Ohio State Medical Association and the Ohio Medical Political Action Committee has been to encourage 100 percent physician-wife registration prior to general elections and 100 percent physician-wife voting at the election.

Following this suggestion, and an outline of how to go about it, Woman's Auxiliary groups of a number of Ohio areas have carried on get-physicians-and-their-wives-registered and to-the-polls programs.

A report from one Auxiliary on this activity in connection with the 1968 general election shows that prior to the election 19 percent of the physicians of the county and voting members of their families were not registered and, therefore, not eligible to vote.

A check of the books at the Board of Elections in that county after the November, 1968, election revealed that 12 percent of the group still were not registered and presumably did not vote in that important election. Amazing, isn't it?

The activity produced some good results, but not good enough. This is not a criticism of the Woman's Auxiliary which worked hard and did a good job. It is an indictment of those who appear to believe that their right to participate in the political affairs of their national, state and community and to be good citizens, means nothing.

—Ohio Medical Political Action Committee



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] tially capsized. The fire departm had to rescue Waters by small b Damage to the yacht is estimate

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

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Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



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Get the Inside Report

ATTEND... THE ANNUAL OMPAC LUNCHEON



ROBERT D. NOVAK

WEDNESDAY, MAY 13, 1970

Second Floor
Sheraton-Columbus Hotel

Speaker . . .
Washington Columnist and Author
ROBERT D. NOVAK

Some facts about Mr. Novak . . .

In 1957, the Associated Press named him Capitol Hill correspondent in Washington, D.C. He joined the Wall Street Journal in 1958 as Senate correspondent and political reporter, and in 1961 became chief Congressional correspondent for the Journal.

In May 1963, Mr. Novak teamed with Mr. Rowland Evans, Jr. to write INSIDE REPORT, a political column, published five times a week. It is noted for its emphasis on reporting rather than punditry, and its rapidly moving dateline.

PROGRAM

11:30 A.M.	Cash Bar
12:00 Noon	Luncheon
12:30 P.M.	After Luncheon Speaker — Robert D. Novak

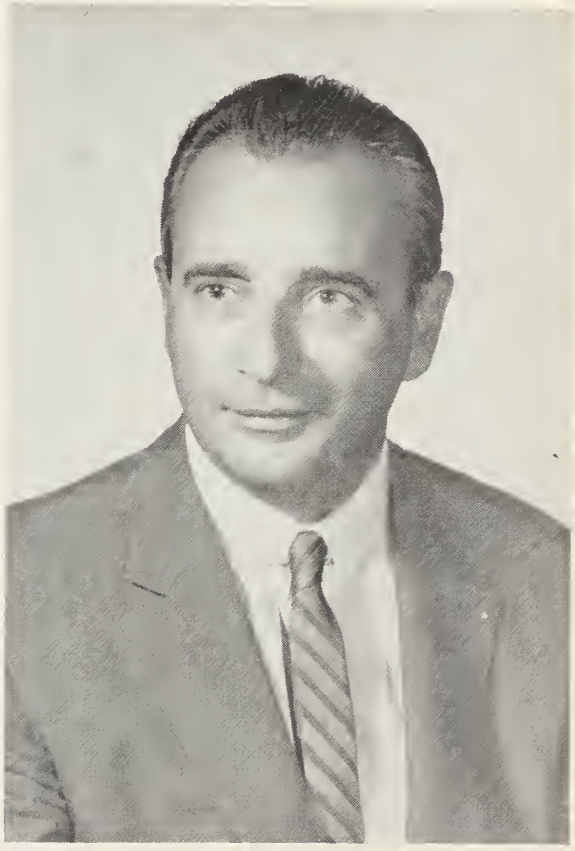
Tickets . . . $5.00 per person

(See reservation blank on page 187)

DID YOU KNOW??

On May 10, 1970, Rex Morgan, M.D., will have been in practice 22 years.





NICHOLAS P. DALLIS, M.D.

His practice, of course, has been limited to the comic pages of some 400 newspapers in the U.S. and Canada, and in 35 Foreign countries.

The author, NICHOLAS P. DALLIS, M.D., former Toledo physician turned full time author of three comic strips, i.e., Rex Morgan, M.D., Judge Parker and Apt. 3-G will share "what his non-fictional patients think about the Medical Profession."

Many Toledo, Ohio people will remember Dr. Dallis as a practicing psychiatrist in the Toledo area for 15 years. Make it a must to attend this GENERAL SESSION on TUESDAY, MAY 12 at 1:30 P.M., VETERANS MEMORIAL BUILDING.

The Title of Dr. Dallis' presentation will be...

"A Fictional Doctor Reveals What his Non-Fictional Patients Think About the Medical Profession"

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Columbus **May 11 - 15**

Leading Downtown Columbus Hotels at Prevailing Rates

Sheraton-Columbus Motor Hotel
50 North Third Street
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Doubles	$20.00 - $25.00
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Neil House Motor Hotel
41 South High Street

Singles	$11.00 - $19.00
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Twins	$15.00 - $23.00

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South High and East Main Streets

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Twins	$14.00 - $17.00

Holiday Inn-Downtown
175 East Town Street

Singles	$13.50
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Christopher Inn
300 East Broad St.
(Wamon's Auxiliory Headquarters)

Singles	$13.50 - $15.00
Doubles	$18.00
Twins	$20.00

Pick-Fort Hayes Hotel
31 West Spring Street

Singles	$12.00 - $17.00
Doubles	$16.00 - $20.00
Twins	$16.00 - $20.00

All rates subject to change.

If you plan to share a room, please indicate name of roommate.

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(Name of Hotel)

_____Columbus, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 11 - 15 (or for period indicated).

_____Single Room _____Twin Room

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Price Range_____

Arrival: May_____at _____ A.M. _____ P.M.

Departure: May_____at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

Name_____

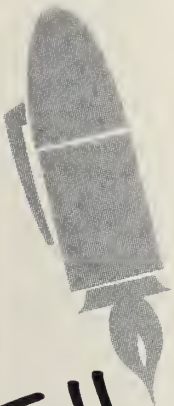
Address_____

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Remember: REGISTER NOW... AVOID LONG LINES SAVE TIME...



Remember the convenience of pre-registration last year? No long lines, no fumbling for your credentials, everything for the meeting in one envelope. It did save time, didn't it? It was so successful that we will be offering this service again this year. In case you have forgotten the procedure, HERE IS HOW IT WORKS – after OSMA receives your PRE-REGISTRATION FORM we will check membership and fill out your registration card. We will then make a badge for you and your wife if you have indicated that she will be attending, place your badge, program and requested social function tickets and luncheon tickets in an envelope in your name. Then all you need to do is come to the PRE-REGISTRATION DESK and ask for your envelope in your name and you are ready to visit the exhibits and attend the meetings of your choice. Make ONE STOP do it, you will be glad you did!!!



Fill It Out

PRE-REGISTRATION FORM

1970 Annual Meeting
Columbus, Ohio

Ohio State Medical Association
May 11 - 15, 1970

Name _____
(Please Print)

Address _____
(Number and Street) (City) (State)

I am:

- ☐ OSMA Member
- ☐ Official OSMA Delegate
- ☐ Official OSMA Alternate
- ☐ Non-member Physician
- ☐ Guest
- ☐ Medical Student
- ☐ Scientific Exhibitor
- ☐ Executive Secretary
- ☐ News Media

Please prepare guest badge for my spouse.

_____
(Please Print Name)

— SOCIAL FUNCTION TICKETS —
RESERVATIONS

Note: (No tickets reserved withaut money)

Moke checks payable ta:
Ohia State Medical Assaciation

Mail this form to:
Ohia State Medical Associatian
17 Sauth High Street, Suite 500
Calumbus, Ohia 43215

Wednesday, May 13, 1970 — 11:30 A.M.
"OMPAC Luncheon" Number
Sheraton-Columbus Hatel
$5.00 per person .....

Wednesday, May 13, 1970 — 7:00 P.M.
"Far East Fling"
Sheraton-Calumbus Hotel
$12.00 per person .....

Thursday, May 14, 1970 — 12:00 Naon
"Exhibitors Luncheon"
Veterons Memorial Building
$4.00 per person .....
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MAIL IT TODAY



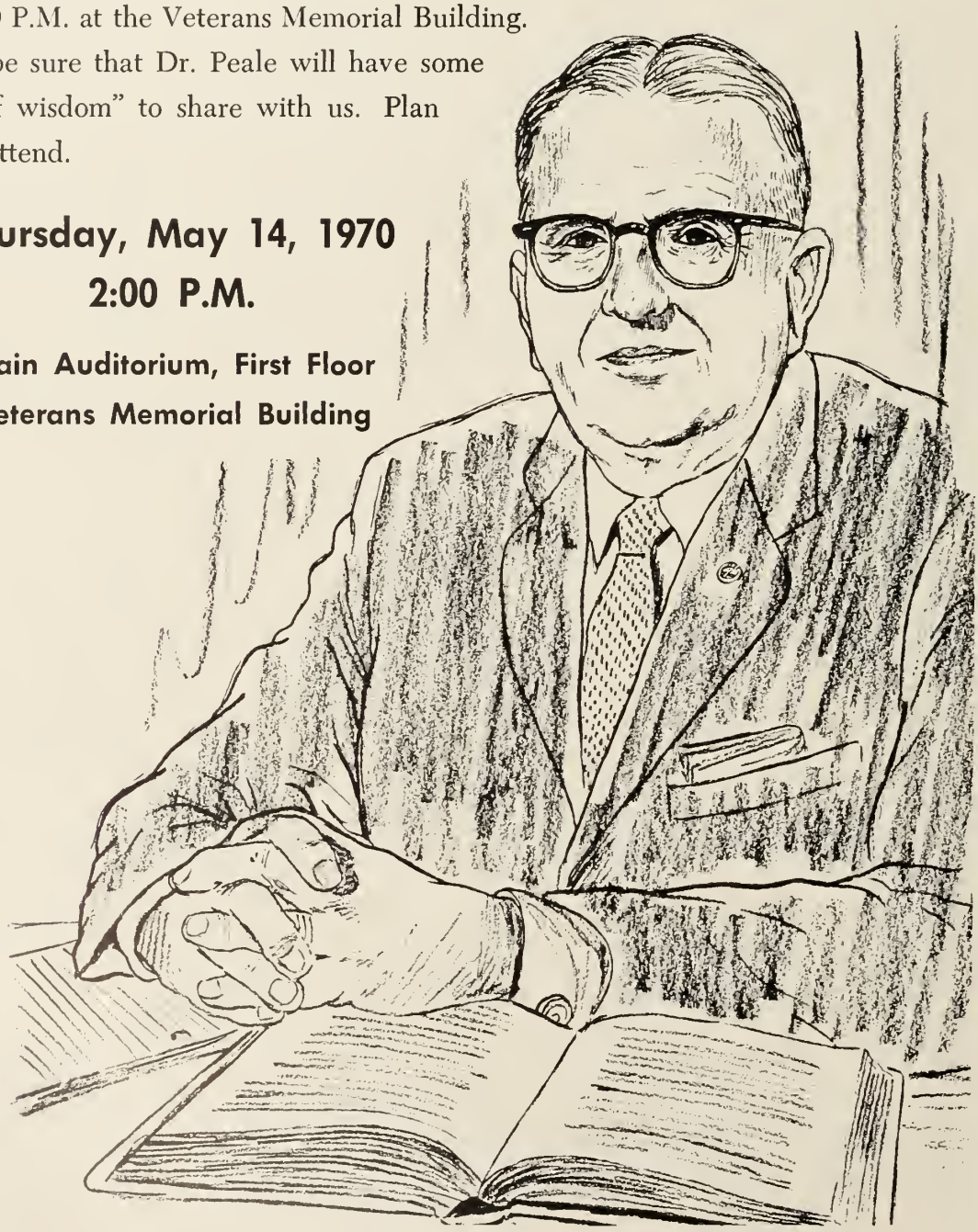
"THE POWER OF POSITIVE THINKING"... has become

almost synonymous with the name DR. NORMAN VINCENT PEALE. Probably no other minister of our time has a more far-flung pulpit than Dr. Peale. Through his books, radio and television programs, speeches and published sermons he has reached and is reaching millions of people throughout the world.

We are privileged to have this former Ohioan as our OSMA General Session speaker on Thursday, May 14 at 2:00 P.M. at the Veterans Memorial Building. We can be sure that Dr. Peale will have some "words of wisdom" to share with us. Plan now to attend.

Thursday, May 14, 1970
2:00 P.M.

Main Auditorium, First Floor
Veterans Memorial Building





Investment Prognosis

By Frank Van Holte, Columbus

THERE SEEMS TO BE an air of extreme pessimism in stock market at this time. A number of the experts are suggesting that we go into hibernation and stay out of the market at least until the middle of the year 1970. I cannot support this gloomy approach. Sitting on the sidelines is a good policy only if you have the ability to pin-point when the market has reached the bottom — and I don't know anyone who has that ability. If you are going to invest your earnings in stocks, I believe that you should position yourself now with the right kind of stocks so that when the tide turns it will catch you and carry you along with it.

How do you select the "right kind of stocks"? Over the long pull there really is no mystery why some stocks do better than others. Let's forget the consideration of business cycles, chart patterns, astrology and cocktail party tips. Appreciation in stocks is almost always geared to earnings prospects, accepting the fact that there will always be short-term fluctuations in stock prices. So try to pick stocks that not only have a good current earnings per share, but equally important, choose companies that have good prospects for future increases in earnings. Generally, when earnings increase, the price of the stock increases.

After you have acquired a good stock, exercise continuous supervision over its earnings, particularly by comparing its actual earnings to its previously estimated earnings. When earnings fall below the expected or anticipated figures, look for a drop in the price of the stock, since price changes are largely tied to changes in earnings. If you follow this method of buying stocks. I'm sure you will be rewarded in the long run. Certainly, it should be an emminently more successful technique than following tips or picking stocks based upon flimsy rumors of a sure rise in price.

When we consider the investment outlook generally, the future looks very favorable for the serious investor with long-term goals. Consider only these facts. Every 7½ seconds a new American is born. That person can expect a 70-year life span and will demand over one million tons of water, 21,000 gallons of gasoline, 10,000 pounds of meat, 28,000 pounds of milk and cream, 9,000 pounds of wheat, 150 pairs of shoes, etc. Now, multiply these figures by the population growth in the next decade and you easily picture the tremendous economic growth we will experience.

Of course, the future has some problems. Think of the daily sonic booms we will have to endure with the advent of supersonic transport planes. But it does not take much of an imagination to foresee the brilliant future for America, and let's ignore these lugubrious expressions of anticipated recessions and depressions. The best is yet to come.

Municipal tax-free bonds are currently offered at all-time high yields. The revised tax passed by Congress removes the threat of taxation of the interest paid on these bonds. I believe that it would be a wise move for physicians to put some of their savings in these bonds. Some day in the near future, when the bond market returns to normalcy, we will look back and wish we had acquired some of these quality municipal bonds providing 6½ percent, 7 percent and even higher tax-free yields.

Mutual funds have made a tremendous impact in the investment industry in the past ten years. A decade ago there were only 155 funds with assets of about $16 billion. Today there are more than 500 funds having assets of approximately $53 billion. I think that this impressive growth is explained by the fact that mutual funds offer small investors the professional help once available only to those individuals who had a large portfolio of investments; namely, supervision by a team of professional investment advisers as well as diversification of investments.

I recently read an interesting report on the high yields on quality corporate bonds. This report pointed out that notwithstanding the 8½ percent coupon, the "real" return was only around 3 percent when you consider 5½ percent inflation rate we are currently experiencing. This means that you are really incurring a loss if your savings dollars are earning less than 5½ percent. This article reminded me of the story about the man who owned a high-powered automobile and left the motor running while he was trying to fill the gas tank at the service station. But the fact is, that we do not really comprehend the eroding effect of inflation.

This monthly feature is written exclusively for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Mead Johnson—pharmaceuticals created for your specialized clinical needs



new 10% solution...
particularly convenient for home use

MUCOMYST®-10
(ACETYLCYSTEINE)

liquefies thick, viscid mucus in chronic bronchitis and emphysema

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

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Calendar of Postgraduate Education for Physicians in Ohio

Periodic Courses

Visiting Surgical Faculty Monthly Seminars — Mercy Hospital, Springfield; 1½ hours a day, once a week, September 11 through May 14, 1970; for specialists and nonspecialists.

Visiting Medical Faculty Weekly Seminars — Mercy Hospital, Springfield; 1½ hours, one day a week through May 30, 1970; for specialists and nonspecialists.

Tumor Conference — Youngstown Hospital Association; two hours a day, once a week, through June, 1970; for specialists and nonspecialists.

Electrocardiography Review — Youngstown Hospital Association; 1½ hours a day, two days a month; through June, 1970; for specialists.

Psychiatric Treatment Methods — Veterans Administration Hospital, Brecksville; three hours a day, one day a month, October 8 through May 13, 1970; for specialists and nonspecialists.

February

Second Annual Seminar on Advances in Clinical Pathology—University of Cincinnati College of Medicine, CONMED, at 104 Medical College Building, Eden and Bethesda Avenues, Cincinnati; February 17; for specialists and nonspecialists.

Cancer Chemotherapy — Regional Conference sponsored by the Northwestern Ohio Institute for Continuing Medical Education, February 17, Bryan High School, Bryan; 7:30 p.m.

A United Approach to a Group of Diseases—Cystic Fibrosis, Osteogenesis Imperfecta, Oxalosis — Sponsored by the Northwestern Ohio Institute for Continuing Medical Education, February 18, 5:00 p.m. at the Medical College of Ohio at Toledo; Lecturer: Clive C. Solomon, Ph.D., associate professor, Department of Pediatrics, University of Colorado.

Gastroenterology—Inflammatory Bowel Diseases—Ohio State University College of Medicine, Columbus, for specialists and nonspecialists, February 18.

Practical Management of Ear, Nose, and Throat Disorders—Ohio State University College of Medicine, Columbus, February 19; for specialists and nonspecialists.

Medical Seminars—Youngstown Hospital Association, South Unit; **Stroke Syndrome and Localization of Lesions,** February 9; **The Hemostatic Process,** February 23.

Orthopedic Problems — Ohio State University College of Medicine, Columbus, February 25; for specialists and nonspecialists.

Selected Topics in Basic and Clinical Immunology — Cleveland Clinic Educational Foundation, February 25-26.

March

13th Annual Ophthalmology Postgraduate Course — Ohio State University College of Medicine, March 2-3; for specialists.

Water and Electrolytes—Basic Science Seminars — Sponsored by Northwestern Ohio Institute for Continuing Education at the Academy of Medicine of Toledo and Lucas County headquarters, 3101 Collingwood Blvd., Toledo; March 3 and 10; 7:30 p.m.

Medical Seminars — The Youngstown Hospital Association, March 9, "Subacute Hepatitis," Drs. D. B. Brown and P. C. Patel; March 23, "Lipoprotein Abnormalities and Coronary Atherosclerosis."

Unwanted Pregnancy—a Preventable Pregnancy—Donald L. Hutchinson, M.D., Pittsburgh, Pa.; Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, March 10, 8:15 p.m.; wives and guests invited.

23rd Annual Medical Symposium—Lorain County Medical Society, 428 West Avenue, Elyria; symposium at Oberlin Inn, Oberlin, March 11.

Pediatric Clinic Day—Ohio State University College of Medicine, Columbus, March 11; for specialists.

Current Management of Common Orthopedic Problems—Cleveland Clinic Educational Foundation, March 11-12; for specialists and nonspecialists.

Clinical Problems in Internal Medicine — Sponsored by the American College of Physicians at the Cleveland Clinic, 2020 East 93rd Street, Cleveland, March 16-20. Details through the ACP office, 4200 Pine Street, Philadelphia, Pa. 19104.

Review Day in General Medicine—Ohio State University College of Medicine, Columbus, March 18.

Annual Cancer Symposium—Akron City Hospital, 525 E. Market Street, Akron, March 18-19; for specialists and nonspecialists.

Practical Management of Infectious Diseases, 1970—Ohio State University College of Medicine; for specialists and nonspecialists; March 25.

Medical Progress and Its Relationship to Dentistry—The Cleveland Clinic Educational Foundation, March 25-26.

Multiple Sclerosis and Related Demyelinating Diseases—Ohio State University College of Medicine, Columbus, March 26; for specialists and nonspecialists.

April

Third Annual Cancer Symposium—Ohio State University College of Medicine, Columbus, April 1; for specialists and nonspecialists.

Advances in Infectious Disease—Cleveland Clinic Educational Foundation, April 1-2.

Recent Advances in Human Genetics — Youngstown Hospital Association, South Unit, Thursday, April 2, 8:00 a.m. Guest Professor, Cecil B. Jacobson, M.D., associate professor of obstetrics and gynecology, George Washington University.

Sports Medicine—Cleveland Clinic Educational Foundation, April 6-7.

New Directions in Coronary Care for the 1970's—American College of Cardiology, at Good Samaritan Hospital, 1425 W. Fairview Ave., Dayton, April 8-9.

Athletic Injuries—Marvin McClellan, M.D., Cincinnati; Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, April 14, 8:15 p.m.

22nd Annual Freedman Lectures in Diagnostic Radiology — University of Cincinnati College of Medicine, April 18-19; Lectures by Dr. Jerome Shapiro, director, Department of Radiology, Boston City Hospital, and professor and chairman of radiology at Boston University Medical School; contact Dr. Benjamin Felson, Department of Radiology, Cincinnati General Hospital, 234 Goodman St., Cincinnati 45229.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Postgraduate Course in Pathology—Cleveland Clinic Educational Foundation, 2020 E. 93rd Street, April 22-23; for specialists and nonspecialists.

Annual Laboratory Animal Medicine Conference—University of Cincinnati College of Medicine, April 25 at Christ Hospital, Cincinnati.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; April 13 — "Mechanisms of Action of Antibiotics," Drs. G. Butcher and N. Pappas; April 27 — "Bronchiectasis — A Review," Drs. H. Bennett and D. Roble.

May

Fifth Annual Conference on the Newborn — Ohio State University College of Medicine, 410 West 10th Avenue, Columbus 43210; May 6; for physicians and nurses.

Progress in Cardiovascular Diseases — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; for specialists and nonspecialists; May 6-7.

Radiology — Youngstown Hospital Association, South Unit, Thursday, May 7, 8:00 a.m.; Guest Professor for the John Heberding Lecture, Milton Elkins, M.D., professor and chairman of radiology at Albert Einstein College of Medicine, New York.

Second Annual Seminar — Trauma of the Head and Neck — University of Cincinnati College of Medicine, CONMED, Eden and Bethesda Avenues, Cincinnati 54219; May 7-9; specialists and nonspecialists.

Kidney Disease Symposium — University of Cincinnati Medical Center, May 20.

Advances in Dermatology — Cleveland Clinic Educational Foundation, May 21-22; for specialists and nonspecialists.

(Continued on Next Page)

(May—Continued)

Refresher Course in Diagnostic Radiology — University of Cincinnati Medical Center, May 24-29.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; May 11 — "Virilism," Drs. C. McGowen and N. Suanprasert; May 25 — "Hypertension in Primary Renal Disease," Drs. R. Bacani and S. Young.

June

Otologic Surgery, Using Live Color Television — University of Cincinnati Medical Center, June 5-9.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; June 8 — "Fungal Infections of the Skin," Drs. K. Lloyd and B. Thimmappa; June 22 — "Diabetic Neuropathy," Drs. L. Green and W. Tsang.

Second Annual Urologic Outing on Controversies in Urology — Sponsored by The Ohio State University Division of Urology at Burr Oak State Park, Ohio, on June 29, 30, and July 1. Modern, air-conditioned facilities. Please contact Program Director Chester C. Winter, M.D., Division of Urology, Ohio State University Medical Center, 410 W. 10th Avenue, Columbus 43210.

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(Copy of Opinion Survey Mailed to OSMA Members)

1970 OHIO STATE MEDICAL ASSOCIATION

Opinion Survey

January 20, 1970

Dear OSMA Member:

I encourage you to take 10 minutes of your time to complete and return this 1970 OSMA survey of its membership.

Here is an opportunity to make your views known to the association officers and to advise as to policy direction. Criticism of past action or inaction has often been the result of poor communication. It is hoped that this attempt to get opinions of the membership will help bridge this communication gap and will provide meaningful data to base policy decisions.

Please return the completed questionnaire in the envelope provided by **February 13, 1970,** otherwise your response cannot be included in the computer tabulations.

The results of the survey will be published in the **Ohio State Medical Journal.**

Sincerely,

Robert N. Smith, M.D.

Robert N. Smith, M.D.
President

IMPORTANT: For proper analysis of survey results, please circle the **one** description that **most** nearly applies to you **in each category:**

FIELD OF PRACTICE —

General Practitioner	1
Specialist	2

TYPE OF PRACTICE —

Private Practice (Solo)	1
Private Practice (Partnership)	2
Private Practice (Group)	3
Administrative Medicine, Research, Industrial or Public Health	4
Medical Education (Full time)	5
Full time in Hospital Service	6
Other	7

AGE —

45 or under	1
Over 45	2

LOCATION OF PRACTICE BY POPULATION —

Over 100,000	1
25,000 - 100,000	2
Less than 25,000	3

(Copy of Opinion Survey Mailed to OSMA Members)

IMPORTANT Circle Appropriate Answers

IBM USE ONLY

1. Which of the following do you utilize in your continuing medical education? (Circle all that apply)

	YES	NO	
a. Educational radio-television	Y	N	
b. Audio tapes	Y	N	
c. Formal courses and lectures	Y	N	
d. County, state and American Medical Association meetings	Y	N	
e. Specialty Society and AAGP meetings	Y	N	
f. Hospital staff meetings	Y	N	
g. Medical literature	Y	N	
h. Contacts with professional colleagues	Y	N	
i. Other	Y	N	

2. Do you feel the Ohio State Medical Association's present activities in continuing medical education should:
(circle only one)

a. Be increased	A	10
b. Be decreased	B	
c. Remain the same	C	

3. Would you favor participation in a continuing medical education program as a requirement for:

	YES	NO	
a. Membership in county and state medical societies?	Y	N	
b. Membership in specialty society or AAGP?	Y	N	
c. Reappointment to hospital staff?	Y	N	
d. Maintenance of license?	Y	N	14

4. Does the scientific portion of the Ohio State Medical Association Annual Meeting provide an important means of your continuing medical education?

YES	NO	
Y	N	15

5. In the past three years have you attended any of the following types of medical meetings?

	YES	NO	
a. Ohio State Medical Association Annual	Y	N	
b. American Medical Association	Y	N	
c. Specialty Society or AAGP	Y	N	
d. Voluntary Health Agency	Y	N	
e. Government sponsored	Y	N	

6. What value do you place on exhibits at the OSMA Annual Meeting as a source of information on drugs, appliances, etc.? (Circle only one)

a. Valuable	A	21
b. Some value	B	
c. Little or no value	C	
d. No opinion	D	

7. Rate the following as to their significance in keeping abreast of OSMA policies and activities: (Circle appropriate letter in each category)

	Very Important	Moderately Important	Not Important	
a. OSMAgram	A	B	C	22
b. Ohio State Medical Journal	A	B	C	23
c. Special Newsletters	A	B	C	24
d. District Councilors	A	B	C	25
e. Local Medical Society Meetings	A	B	C	26

8. Do you feel the OSMA has done a satisfactory job in keeping you informed on the following?

	YES	NO	
a. Legislative matters	Y	N	27
b. Scientific advances	Y	N	28
c. Medical socio-economic matters	Y	N	29
d. OSMA policies and activities	Y	N	30

9. Do you favor the employment of trained "physician's assistant" to work in physicians' offices performing such tasks as:

	YES	NO	
a. Preliminary screening for illness	Y	N	31
b. Well-baby examinations	Y	N	32
c. Family planning	Y	N	33

10. Have you in the past 12 months contacted a legislator on a specific issue involving medicine and public health?

YES	NO	
Y	N	34

11. Do you feel the OSMA should give consideration to developing a form of membership for medical students?

YES	NO	
Y	N	35

12. The American Medical Association has changed its bylaws so that qualified Doctors of Osteopathy may be admitted to full active membership in the AMA with the constituent associations and component county societies being the judge of those so qualified. Do you agree with this action?

YES	NO	
Y	N	36

13. How would you rate the following as public health problems in Ohio today? (Circle appropriate letter in each category)

	Very Pressing	Moderately Pressing	Not Pressing	
a. Air pollution	A	B	C	37
b. Water pollution	A	B	C	38
c. Alcoholism	A	B	C	39
d. Drug abuse	A	B	C	40
e. Infant mortality	A	B	C	41
f. Malnutrition	A	B	C	42
g. Mental health	A	B	C	43

14. Do you feel that the medical profession has done a satisfactory job of enforcing its self-imposed ethics?

YES	NO	
Y	N	44

15. Would you be willing to serve on the following committees?

	YES	NO	
a. Professional Ethics	Y	N	45
b. Fee Review	Y	N	46
c. Utilization Review	Y	N	47

16. Estimate the number of hours you work per week, including professional reading, paper work, preparation of scientific papers, office management and committee meetings. (Circle only one)

a. Under 50 hours	A	48
b. 50-60 hours	B	
c. 60-70 hours	C	
d. Over 70 hours	D	

17. Do you "direct bill":

	YES	NO	
a. Welfare and Medicaid patients?	Y	N	49
b. Medicare patients?	Y	N	50
c. Private patients?	Y	N	51
d. Non Applicable?	N.A.		52

18. What comments do you have about the American Medical Association?

19. What comments do you have about the Ohio State Medical Association?

Circle your County Medical Society:

NUMERICAL CODE
OHIO COUNTIES

Adams	01	Fairfield	23	Licking	45	Portage	67
Allen	02	Fayette	24	Logan	46	Preble	68
Ashland	03	Franklin	25	Lorain	47	Putnam	69
Ashtabula	04	Fulton	26	Lucas	48	Richland	70
Athens	05	Gallia	27	Madison	49	Ross	71
Auglaize	06	Geauga	28	Mahoning	50	Sandusky	72
Belmont	07	Greene	29	Marion	51	Scioto	73
Brown	08	Guernsey	30	Medina	52	Seneca	74
Butler	09	Hamilton	31	Meigs	53	Shelby	75
Carroll	10	Hancock	32	Mercer	54	Stark	76
Champaign	11	Hardin	33	Miami	55	Summit	77
Clark	12	Harrison	34	Monroe	56	Trumbull	78
Clermont	13	Henry	35	Montgomery	57	Tuscarawas	79
Clinton	14	Highland	36	Morgan	58	Union	80
Columbiana	15	Hocking	37	Morrow	59	Van Wert	81
Coshocton	16	Holmes	38	Muskingum	60	Vinton	82
Crawford	17	Huron	39	Noble	61	Warren	83
Cuyahoga	18	Jackson	40	Ottawa	62	Washington	84
Darke	19	Jefferson	41	Paulding	63	Wayne	85
Defiance	20	Knox	42	Perry	64	Williams	86
Delaware	21	Lake	43	Pickaway	65	Wood	87
Erie	22	Lawrence	44	Pike	66	Wyandot	88
Out of State	00						

Woman's Auxiliary Highlights...

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

TODAY IS MONDAY (or so it was at the time of this writing)! It is (was) the first day after the holidays and signaled a return to more normal routines. For you doctors the difference in the daily pattern may not have been too noticeable. Family physicians were busy curing everybody in time for the parties or reunions or trips. Surgeons probably had fewer elective procedures but emergencies were no respector of festivities.

For you wives and mothers the greatest evidence of normalcy was that the kids were back in school and there were meetings on your calendars. You were probably faced with putting away the decorations, cleaning out the refrigerator and laundering mountains of clothes.

In mid-December Auxiliary activities had slowly ground to a halt after members had done what they could to bring holiday cheer to those less fortunate. We had donated gifts for youngsters, had entertained shut-ins, had helped with the Christmas seal drive and the Salvation Army collections. Then we took time out from all our good works and concentrated on our families, baked cookies for our friends, shopped endless hours, helped with the church pageant or attended extra choir rehearsals for special services. Now it was all over.

And so it is the first Monday of just another month. To me this means four things: a morning rehearsal with the Auxiliary Choral Group, an approaching deadline for this column, and two evening meetings! Is there any state or county auxiliary activity to report? Somewhere in the Christmas mail there was a letter from our indefatigable state president. Ruth Meltzer called for quarterly reports and reminded state officers and chairmen of the midwinter Board meeting in January.

Jane Sloan, nominating chairman and immediate past president, had gathered her committee together early in December. Letters and phone calls went out across the state and a new slate of officers was born.

Mrs. C. A. Colombi sent a delightful note from Denver where she was "having a ball renewing old acquaintances" while her husband was attending AMA clinical meetings. Vi indicated that she was lunching with "a gal who was president of the Colorado Auxiliary when I was president of the Ohio Auxiliary and with the gal who was president-elect of the Colorado Auxiliary when we all attended the national conference in Chicago in 1960." In other words, working in the state auxiliary nets a bonus of friends all over the country.

Scioto County Reports

Mrs. L. B. Hatch, of South Webster, sent me a clipping about *Scioto County's* December meeting. Holly and candles decorated tables at Harold's Restaurant for this Christmas luncheon. Mrs. Burl E. Pritt was the guest speaker, talking and showing slides of her recent trip to the Holy Land. Committee members for the day included: Mrs. P. D.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Portsmouth, 45662

President-Elect
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1001 Granard Parkway
Steubenville, 43952

Past President
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415 Towerview Road
Dayton, 45429

First Vice-President
Mrs. Paul A. Jones
423 Coventry Circle
Zanesville, 43701

Second Vice-President
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2280 W. Wayne Street
Lima, 45805

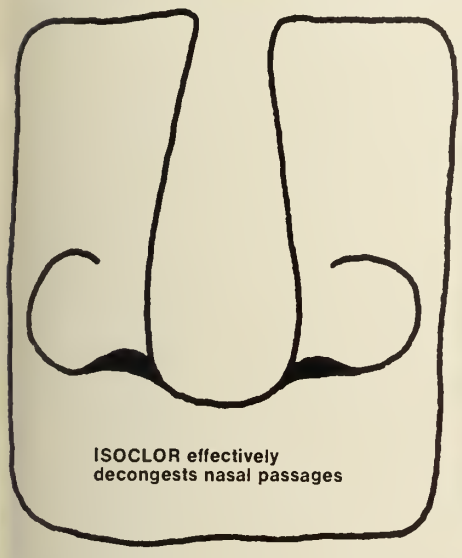
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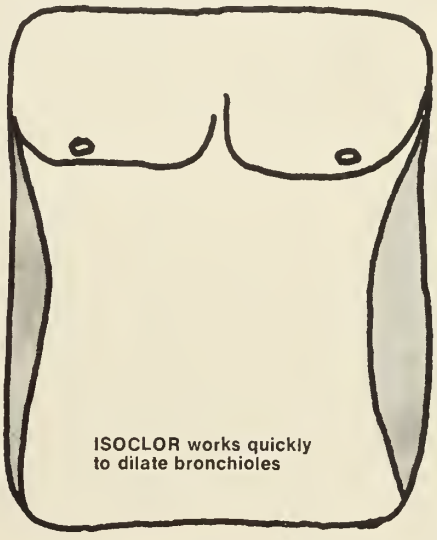
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Lucasville, 45648

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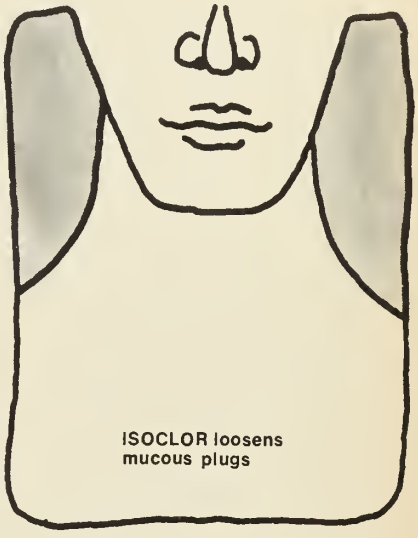
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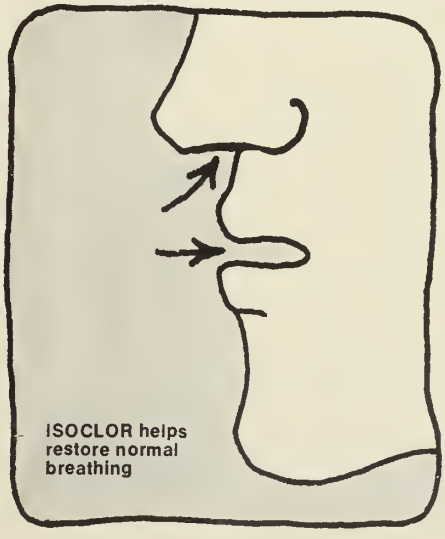
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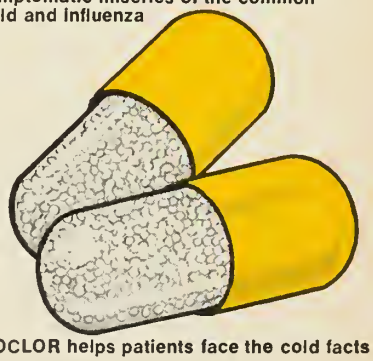


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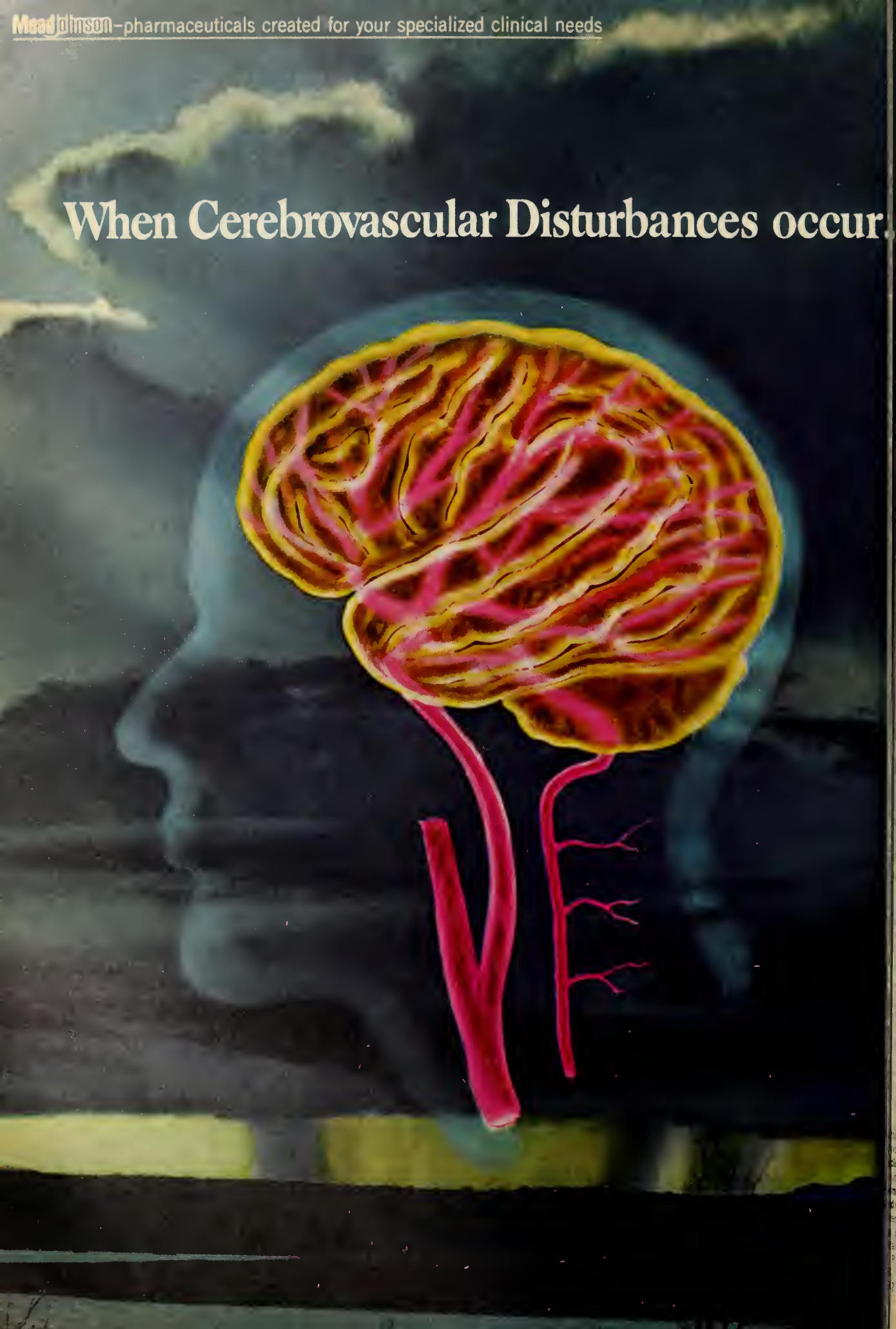
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71169

Weems, Mrs. Sol Asch, Mrs. Carl G. Braunlin, Mrs. Spencer W. Miller, Mrs. Spencer K. Miller and Mrs. Jerome M. Rini.

Urgent Request from National

A letter from our national auxiliary president, Mrs. John M. Chenault, may have been buried in the avalanche of your holiday mail. Medical students are currently facing a financial crisis. Mrs. Chenault states that more funds are needed desperately for AMA-ERF's Student Loan Guarantee Program for the following reasons:

1. Appropriations of federal funds are inadequate to meet the growing need for more student loans.
2. Tight money and high interest rates have made it increasingly difficult for many students to obtain commercial loans.
3. The high cost of living and learning (tuition, books, rent) plus inflationary trends depletes meager student budgets.

We have all been supporting various fund raising projects for AMA-ERF. Most of this money has been earmarked for specific medical schools. Perhaps we could all "take one small step" for the future of American medicine and contribute directly to the loan program. Please give your contribution to your county AMA-ERF chairman. Make checks payable to AMA-ERF Auxiliary Fund and indicate that your gift is to be used for the Student Loan Guarantee Program. If you do not know your county chairman, send your contribution to the state chairman, Mrs. Karl Ulicny, 864 Highland Ave., Salem 44460.

Dr. Henry A. Crawford, Cleveland, has been named a member of State Advisory Board to the newly created Division on Aging of the Ohio Department of Mental Hygiene and Correction. Dr. Crawford is a Past President of the Academy of Medicine of Cleveland and of the Ohio State Medical Association, and is a member of the State Medical Board of Ohio.

Dr. Claude S. Perry, Columbus, spoke on diabetic retinitis at several centers in South Africa on a fall tour. He spoke for the Durban Ophthalmological Society, addressed the Ophthalmological staff and residents of the Groote-Schuur Hospital under the direction of Dr. Christiaan Barnard, Capetown, and appeared before the staff of the Gunderson Horness Mission Hospital, Rhodesia.



Ad Astra

Anthony Joseph Bayuk, M.D., Youngstown; University of Pittsburgh School of Medicine, 1942; aged 51; died December 3; member of the Ohio State Medical Association, the American Medical Association, American Society of Anesthesiologists, and the International Anesthesia Research Society; Fellow of the International College of Surgeons; diplomate of the American Board of Anesthesiology; specialist in anesthesiology in Youngstown for 23 years; associated with St. Elizabeth Hospital; member of St. Dominic Church and the Elks Lodge; veteran of World War II; survived by his widow, a daughter, two sons, and a brother.

Wilbur Glenn Carlisle, M.D., Bucyrus; Johns Hopkins University School of Medicine, 1913; aged 81; died December 16; member of the Ohio State Medical Association and the American Medical Association; practitioner for 55 years; resident of Bucyrus since 1914; city health commissioner, and associated with many other professional activities in the community; member of the Rotary Club, the Presbyterian Church, Masonic, Elks, Eagles, and Moose Lodges, and the Chamber of Commerce; veteran of World War I; survived by a son, a daughter, a brother, and a sister.

Edward B. Castle, M.D., Cleveland and Lakewood; University of Michigan School of Medicine, 1929; aged 63; died November 23 in a private plane crash; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery; surgeon for many years in Cleveland and head of an industrial practice; formerly associated in practice with his father, the late Dr. Morrison H. Castle; veteran of World War II; survived by two sons.

Anthony Cosimo Catalano, M.D., Cleveland; Ohio State University College of Medicine, 1926; aged 73; died December 1; former member of the Ohio State Medical Association; practitioner in the southeast area of Greater Cleveland for some 43 years; veteran of World War II; final rites from St. Timothy Catholic Church; survived by his widow, a daughter, two brothers, and two sisters.

David Pressley Findley, M.D., Kent; Jefferson Medical College of Philadelphia, 1930; aged 64; died December 6; staff physician at the Kent State University Health Center for four years; previously at St. Christopher's Mission, at Bluff, Utah, and before that associated with the Montana State Board of Health; survived by his widow, two daughters, two brothers, and a sister.

Gerald Alonzo Foster, M.D., Coshocton; University of Cincinnati College of Medicine, 1936; aged 60; died December 18; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; past president of the Coshocton County Medical Society; practicing physician in the Coshocton area for 32 years; member of the Governor's Planning Commission on Mental Health and the Coshocton County Advisory Board on Mental Health; member of the Methodist Church; survived by his widow, two sons, and a daughter.

Ethel Knisley Fuetterer, M.D., Cuyahoga Falls; University of Michigan Homeopathic Medical School, 1908; aged 85; died December 20; practitioner in Cuyahoga Falls before her retirement in 1954; survived by two daughters.

Walter Isaac Jenkins, M.D., McAllen, Texas; University of Cincinnati College of Medicine, 1917; aged 79; died June 9; member of the Ohio State Medical Association and the American Medical Association; native Ohioan and practitioner in Akron from 1920 to the time of his retirement in 1955; served as a medical officer during World War I; living in retirement in Texas for a number of years.

Hilding Robert Johanson, M.D., Kenton; Wayne State University School of Medicine, 1932; aged 62; died November 25; member of the Ohio State Medical Association; practitioner of long

standing in the Kenton area, where he specialized in the EENT field; served as Hardin County coroner and county health commissioner; member of the Masonic and Elks Lodges, the Lions Club, and the Church of Christ; veteran of World War II; survived by his widow, a daughter, two sons, and a sister.

Maynard C. Kiser, M.D., Tipp City; University of Cincinnati College of Medicine, 1934; aged 59; died December 9; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the Industrial Medical Association; native of Miami County, and practitioner there since 1935; also physician for industrial firms in the area; member of the Lutheran Church, Masonic Lodge, Rotary Club, and other organizations; active in youth and Boy Scout work; survived by his widow, a son, a daughter, and his mother. His father was the late Dr. Foster D. Kiser, who formerly practiced in Tipp City.

Helmut Friedrich Kutt, M.D., Brecksville; medical degree from the University of Tartu, Estonia, 1943; aged 56; died November 11; physician on the staff of the Veterans Administration Hospital at Brecksville; previously on the staff of the Massillon State Hospital; survived by his widow, Dr. Anastasia Kutt, who also is a physician at the Brecksville VA Hospital; and by a brother.

Leslie L. Lawrence, M.D., Canton; Western Reserve University School of Medicine, 1926; aged 69; died December 7; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; retired after active practice as physician and surgeon in the Canton area; veteran of World Wars I and II; member of the Christian Church; member and past president of the Canton Symphony Orchestra; survived by his widow, a son, and two daughters.

Edward Carl Nehls, M.D., South Charleston; Starling-Ohio Medical College, Columbus, 1912; aged 82; died December 12; member of the Ohio State Medical Association and the American Medical Association; practitioner of long standing South Charleston area; veteran of World War I; past president of the local Lions Club and the Clark County Board of Health; member of the Lutheran Church, American Legion, and several Masonic bodies; survived by his widow, a daughter, a brother, and a sister.

Abraham D. Papish, M.D., Cleveland; University of Toronto Faculty of Medicine, 1924; aged 70; died December 16; practitioner in the Cleveland area for some 40 years, specializing in internal medicine; surviving are his widow, a daughter, and a son, Dr. Irwin Papish, of Washington, D.C.

Hiram Page Petty, M.D., Loudenville; University of Pittsburgh School of Medicine, 1923; aged 72; died December 17; member of the Ohio State Medical Association; practitioner of long standing in Loudenville and for the past 12 years Ashland County and city health commissioner; also county coroner; member of the Presbyterian Church; survived by his widow, three daughters, and a sister.

Burton Van Dyke Scheib, M.D., Toledo; Indiana University School of Medicine, 1936; aged 57; died December 28; member of the Ohio State Medical Association and the American Medical Association; Fellow of the International College of Surgeons and of the American College of Surgeons; practitioner in Toledo where he specialized in orthopaedic surgery; veteran of World War II during which he served with the Navy.

Fred Schoepfle, M.D., Sandusky; University of Michigan School of Medicine, 1906; aged 86; died November 23; member of the Ohio State Medical Association and the American Medical Association; lifelong resident of Sandusky and practitioner there for 57 years; survived by a son, Dr. Tom F. Schoepfle, also of Sandusky, a daughter, and a sister.

Allen A. Tombaugh, M.D., Lansing, Mich.; Ohio State University College of Medicine, 1918; aged 74; died October 21; former member of the Ohio State Medical Association; formerly practiced in the Cambridge area where he was associated with the Rocky Glen Sanatorium; veteran of World War I; survived by his widow, three daughters, a son, and two sisters.

Gene Armour Welch, M.D., Ithaca, N.Y.; McGill University Faculty of Medicine, 1956; aged 39; died December 10; former resident of Ohio who took his internship training at Cincinnati General Hospital before leaving the state.

County Societies' Officers and Meeting Dates

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High St.

ADAMS—Gary J. Greenlee, President, Farmers' Bank Building, Manchester 45144; Hazel Sproull, Secretary, P.O. Box 337, West Union 45693, 3rd Thursday, April, July, Oct. and Jan.

BROWN—Philip Pfalzgraf, President, Ohio Pike, Amelia 45102; Robert Benintendi, Secretary, 117 Cherry St., Georgetown 45121. 3rd Sunday (variable).

BUTLER—John H. Varney, President, 3207 Sheldon Rd., Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, 110 North Third St., Hamilton 45011. 4th Wednesday.

CLERMONT—Kurt Platschik, President, 4450 Mt. Carmel-Tobasco Road, Cincinnati 45244; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103; 3rd Wednesday except July, August and December.

CLINTON—Arthur F. Lippert, President, 110 East Locust St., Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday.

HAMILTON—Robert S. Heidt, President, 2340 Auburn Ave., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday, except June, July, Aug. and Dec.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson St., Greenfield 45123.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason 45040; Orville L. Layman, Secretary, 22 West Fourth St., Franklin 45005. 2nd Tuesday.

Second District

Councilor: George J. Schroer, Ft. Loramie 45845
20 S. Main St.

CHAMPAIGN—Fred R. Denkewalter, President, 848 Scioto St., Urbana 43078; Terrence F. Grogan, Secretary, 848 Scioto St., Urbana 43708. 2nd Wednesday.

CLARK—Wesley E. Knaup, President, 1054 East High St., Springfield 45505; Mrs. Marion Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone St., Springfield 45503. 3rd Monday, except June, July, Aug. and Dec.

DARKE—E. W. Browne, President, 330½ West Fourth Street, Greenville 45331; Giles Wolverton, Secretary, Health Department, Court House, Greenville 45331. 3rd Tuesday.

GREENE—Rudi Sotlar, President, 12 South Limestone Street, Jamestown 45335; Mrs. W. F. Whitt, Executive Secretary, P.O. Box 249, Chardon 44024. Last Friday of every month.

MIAMI COUNTY—Kenneth Faze, President, 3 Duerr Drive, West Milton 45383; Martha L. Derr, Executive Secretary, P.O. Box 467, Piqua 45356. 1st Tuesday.

MONTGOMERY—Robert A. Bruce, President, 1126 South Main St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. Monthly meeting dates as established.

PREBLE—J. D. Darrow, President, 228 North Barron St., Eaton 45320; J. R. Williams, Secretary, 228 North Barron St., Eaton 45320. No regular meeting date.

SHELBY—George Schroer, President, 20 S. Main Street, Fort Loramie 45845; Alfonsas Kisielius, Secretary, Ohio Building, Sidney 45365. Quarterly meetings.

Third District

Councilor: Dwight L. Becker, Lima 45802
Box 1272

ALLEN—Alexander C. Reed, President, 819 West North St., Lima 45801; William E. Noble, Secretary, c/o Memorial Hospital, Linden & Mobel Ave., Lima 45804. 3rd Tuesday.

AUGLAIZE—John F. Bowling, President, N. Knoxville Rd., St. Marys 45885; Barbara Cummins, Secretary, 310 Perry St., Wapakoneta 45895. 1st Thursday every other month, starting with January.

CRAWFORD—Horace B. Newhard, President, 140 Hill St., Bucyrus 44820; C. Fabrigar, Secretary, 139 Gaius St., Bucyrus 44820. Meeting date variable.

HANCOCK—Charles D. Fess, President, Ohio Bank Building, Findlay 45840; James A. Miller, Secretary, 1119 North Main St., Findlay 45840. 1st Tuesday.

HARDIN—Robert A. Thomas, President, Mount Victory 43340; Jay Pfeiffer, Secretary, 215 North Main St., Kenton 43326. 2nd Tuesday evening.

LOGAN—Joseph Terebuh, President, Colonial Arms, Apt. 10, Bellefontaine 43311. George Gensemer, Secretary, 834 North Main, Bellefontaine 43311. 1st Friday.

MARION—Robert C. Campbell, President, 1028 East Center St., Marion 43302; Jerome A. Wensinger, Secretary, Smith Clinic, 1040 Delaware Ave. 43302. 1st Tuesday.

MERCER—George H. McIlroy, President, 123 East Fayette St., Celina 45822; D. J. Schwieterman, Secretary, Rolfes Rd., Maria Stein 45860. 3rd Thursday.

SENECA—Leroy Cummings, President, 60 Sycamore St., Tiffin 44883; Donald Shanabrook, Secretary, 455 West Market St., Tiffin 44883. 3rd Tuesday evening Jan., March, May, July, Sept. and Nov.

VAN WERT—Thomas R. Wilson, President, Van Wert County Hospital, Van Wert 45891; Robert Scheidt, Secretary, Medical Arts Building, Van Wert 45891. 3rd Friday.

WYANDOT—D. P. Smith, President, Pennington St., Sycamore 44882; K. K. Solacoff, Secretary, 777 North Sandusky Avenue, Upper Sandusky. 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43624
316 Michigan St.

DEFIANCE—Jack A. Kane, President, Central Foundry, Defiance 43512; Miss Lois Coffin, Executive Secretary, P.O. Box 386, Defiance 43512. 1st Saturday.

FULTON—R. L. Davis, President, 137 South Fulton St., Wauseon 43567; M. S. Renfrew, Secretary, Lutz Rd., Archbold 43502. Quarterly meetings March, June, Sept. and Dec.

County Society Roster (continued)

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545; B. L. Sickmiller, Secretary, 1400 E. Second St., Defiance 43512.

LUCAS—Peter A. Overstreet, President, 2800 West Central Ave., Toledo 43606; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday.

OTTAWA—R. W. Minick, President, Port Clinton Rd., Oak Harbor 43449; H. A. Boker, Secretary, 113 Columbus Ave., Lakeside 43440. 2nd Thursday.

PAULDING—Richard D. Stagg, President, Route 2, Paulding 45879; Kirkwood A. Pritchard, Secretary, 119 South Main St., Paulding 45879. Called meetings.

PUTNAM—James B. Overmier, President, 109 Main St., Leipsic 45856; Arthur P. Daniel, Secretary, 144 North Walnut St., Ottawa 45876. 1st Tuesday.

SANDUSKY—E. F. Dierksheide, President, 528 Third Ave., Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday.

WILLIAMS—V. L. Boerger, President, Edgerton 43517; L. Rivera, Secretary, 307 First St., Pioneer 43554. 3rd Tuesday.

WOOD—Gerald G. Woods, President, 513 Superior St., Rossford 43460; L. J. Eulberg, Secretary, 135 East Front St., Pemberville 43450. 3rd Thursday.

Fifth District

Councilor: P. John Robechek, Cleveland 44122
3461 Warrensville Center Rd.

ASHTABULA—W. B. Millberg, President, 430 West 25th Street, Ashtabula 44004; Miss Dorothy L. Geho, Executive Secretary, P.O. Box 205, Geneva 44041. 2nd Tuesday.

CUYAHOGA—Leo Walzer, President, 11811 Shaker Blvd, Cleveland 44120; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106. Board meets 2nd Tuesday.

GEAUGA—Oscar Brinckmann, President, 12475 Hospital Dr., Chardon 44024; Adrian Krudy, Secretary, Radiology Dept., Geauga Community Hospital, P.O. Box 249, Chardon 44024. 2nd Friday.

LAKE—John J. Cahill, President, 36001 Euclid Ave., Willoughby 44060; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44094. 4th Wednesday of Jan., March, May, Sept. and Nov.

Sixth District

Councilor: Maurice F. Lieber, Canton 44703
515 Third St., N. W.

COLUMBIANA—Wade A. Bacon, President, 356 Lincoln Way, Lisbon 44432; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460, 3rd Tuesday.

MAHONING—Robert L. Jenkins, President, 21 Wickliffe Circle, Youngstown Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44505. 3rd Tuesday, except June, July and August.

PORTAGE—Kenneth F. Rupp, President, 9160 State Route 43, Streetsboro 44240; Miss Maria Motyka, Executive Secretary, 430 Grant St., Akron 44311. 3rd. Tuesday.

STARK—Frank O. Goodnough, President, Peoples-Merchants Trust Building, Massillon 44646; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday.

SUMMIT—Edwin W. Cauffield, President, 505 Ohio Building, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 2nd Tuesday, excluding July and August.

TRUMBULL—J. R. Phillips, President, St. Joseph's Hospital, N. Tod Avenue, Warren 44485; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday, September through May.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth St.

BELMONT—Thomas L. Ring, President, 3205 Belmont Street, Bellaire 43906; Bertha M. Joseph, Secretary 100 South 4th Street, Martins Ferry 43935. 3rd Thursdays, except January, May, July and August.

CARROLL—T. J. Atchison, President, 292 East Main St., Carrollton 44615; Jack L. Maffett, Secretary, 264 South Lisbon St., Carrollton 44615. 3rd Tuesday.

COSHOCTON—Myron Saturski, President, 149 South Bridge Street, Newcomerstown 43832; Robert W. Secrest, Secretary, 1926 Melbourne Road, Coshocton 43812. 2nd Tuesday.

HARRISON—R. W. Weiser, President, Jewett 43986; Janis Trupovnieks, Secretary, Hopedale 43976. Quarterly, March, June, Sept. and Dec.

JEFFERSON—Crist G. Strovilas, President, 812 North Fourth St., Toronto 43964; Mary Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952. 4th Tuesday, except Aug. and Dec.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—C. M. Comella, President, 700 Boulevard, Dover 44622; R. L. Gerber, Secretary, 126 South Broadway, Sugarcreek 44663.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson

ATHENS—Dale Mattmiller, President, Hudson Health Center, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. Second Tuesday except July and August.

FAIRFIELD—R. A. Welsh, President, Lancaster-Fairfield Hospital, Lancaster 43130; C. R. Reed, Secretary, 309 East Main Street, Lancaster 43130. 2nd Tuesday.

GUERNSEY—Richard F. Whiteleather, President, 1432 Clark St., Cambridge 43725; Quentin F. Knauer, Secretary, 100 Clark St., Cambridge 43725. 1st Tuesday.

LICKING—Charles Sinsabaugh, President, 1272 West Main St., Newark 43055; Robert P. Raker, Secretary, 117 East Elm St., Granville 43023. 4th Tuesday.

MORGAN—Asa Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 East Union Ave., McConnelsville 43756.

MUSKINGUM—James F. Morton, President, 727 Market St., Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Ave., Zanesville 43701. 1st Tuesday.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Box 239, Caldwell 43724. 1st Tuesday.

County Society Roster (continued)

PERRY—Ralph E. Herendeen, Jr., President, 203 North Main St., New Lexington 43764; Alfredo G. Cruz, Secretary, 203 North Main St., New Lexington 43764.

WASHINGTON—Tom D. Halliday, President, 409 2nd St., Marietta 45750; Gilberto D. Gutierrez, Secretary, c/o Marietta Memorial Hospital, Marietta 45750. 2nd Wednesday.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—James A. Kemp, President, Holzer Medical Center, Gallipolis 45631; Donald M. Thaler, Secretary, Holzer Medical Center, Gallipolis 45631. Quarterly meetings at call.

HOCKING—Jan Mathews, President, 9 East 2nd St., Logan 43138.

JACKSON—Earl Levine, President, 120 North Ohio Avenue, Wellston 45692; John M. Cook, Secretary, Box 316, Oak Hill 45656. Meetings when called.

LAWRENCE—A. Burton Payne, President, 411 Center Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly meetings.

MEIGS—Charles J. Mullen, President, 210½ East Main St., Pomeroy 45769; E. Butrimas, Secretary, 204 East Main St., Pomeroy 45769.

PIKE—A. M. Shrader, President 196 Emmett Ave., Waverly 45690; R. M. Eaton, Secretary, 709 Crestwood Dr., Waverly 45690. 1st Wednesday.

SCIOTO—Joseph T. Gohmann, President, Mercy Hospital, 1248 Kinneys Lane, Portsmouth 45662; Mr. Lowell Thompson, Executive Secretary, 1805 27th St., Portsmouth 45662. 6:30 2nd Tuesday.

VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050
104 E. Gambier St.

DELAWARE—John L. Binkhorst, President, 26 Northwood Dr., Delaware 43015; Lloyd E. Moore, Secretary, Magnetic Springs 43036. 3rd Tuesday except June, July and Aug.

FAYETTE—H. W. Payton, President, 36 South Main Street, Jeffersonville 43163; M. H. Roszmann, Secretary, 1005 East Temple Street, Washington C. H. 43160. 2nd Friday.

FRANKLIN—Samuel A. Marable, President, 410 West Tenth Ave., Columbus 43210; Mr. W. "Bill" Webb, Executive Secretary, 17 South High St., Suite 528, Columbus 43215. 3rd Tuesday except June, July and Aug.

KNOX—James C. McCann, President, Medical Arts Building, Mount Vernon 43050; Robert Westerheide, Secretary, Medical Arts Building, Mount Vernon 43050. 1st Wednesday.

MADISON—Brawley Arikawa, President, 176 North Madison Road, London 43140; William T. Bacon, Secretary, 194 Elm Street, London 43140. Four times a year, 2nd Wednesday (3, 6, 9, 12).

MORROW—William Deffenger, President, Box 8, Marengo 43334; Francis Kubbs, Secretary, 140 Main St., Mount Gilead 43338. 1st Tuesday.

PICKAWAY—H. H. Swope, President, 400 North Court St., Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney St., Circleville 43113. 1st Tuesday except July and Aug.

ROSS—Roy Manning, President, 1 Overlook Dr., Chillicothe 45601; Paul MacCarter, Secretary, 60 Central Center, Chillicothe 45601. 1st Thursday.

UNION—John R. Linscott, President, 225 Stocksdale Dr., Marysville 43040; May B. Zaugg, Secretary, Route 5, Timber Trails, Marysville 43040. 1st Tuesday of Feb., April, Oct. and Dec.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Rd.

ASHLAND—William Emery, President, 247 Sandusky Street, Ashland 44805; J. H. Cooperrider, Secretary, 637 North Union Street, Loudonville 44842. 1st Thursday.

ERIE—R. H. Williamson, President, 410 Wasta Rd., Huron 44839; Mrs. Barbara Wolfert, Executive Secretary, 1428 Hollyrood Rd., Sandusky 44870. 2nd Tuesday except July and Aug.

HOLMES—M. Robert Huston, President, 109 South Clay St., Millersburg 44654; Daniel J. Miller, Secretary, Box 143, Walnut Creek 44687. 2nd Thursday.

HURON—Wm. B. Holman, President, 257 Benedict Ave., Norwalk 44857; John E. Rosso, Secretary, 218 Myrtle Ave., Willard 44890, 2nd Wednesday, Feb., April, June, Oct., and Dec.

LORAIN—Robert P. McFarland, President, Oberlin Clinic, Inc., 224 West Lorain Street, Oberlin 44074; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday for REGULAR MEETINGS. Last Thursday of the month for COUNCIL MEETINGS.

MEDINA—H. E. Grover, President, 146 North Lyman Street, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina 44256. 3rd Thursday.

RICHLAND—Robert W. Jones, President, 120 Sturges Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, c/o Mansfield General Hospital, Mansfield 44903. 3rd Thursday except June, July and August.

WAYNE—Frank Cebul, President, 1740 Cleveland Road, Wooster 44691; Thomas Graves, Secretary, 1740 Cleveland Road, Wooster 44691. 2nd Wednesday of alternate months.

For Roster of OSMA Officers and Committeemen
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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

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(Continued from Previous Page)

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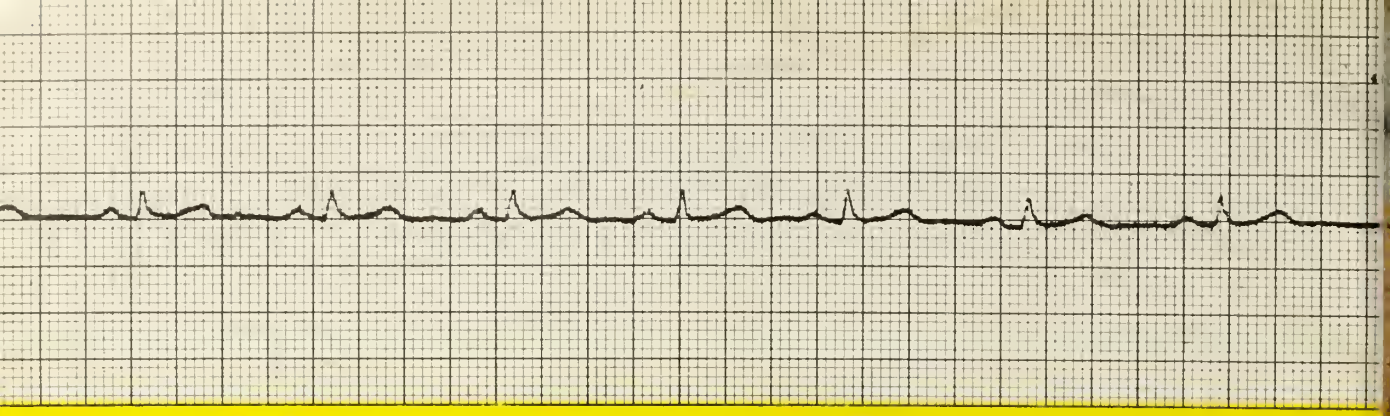
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION



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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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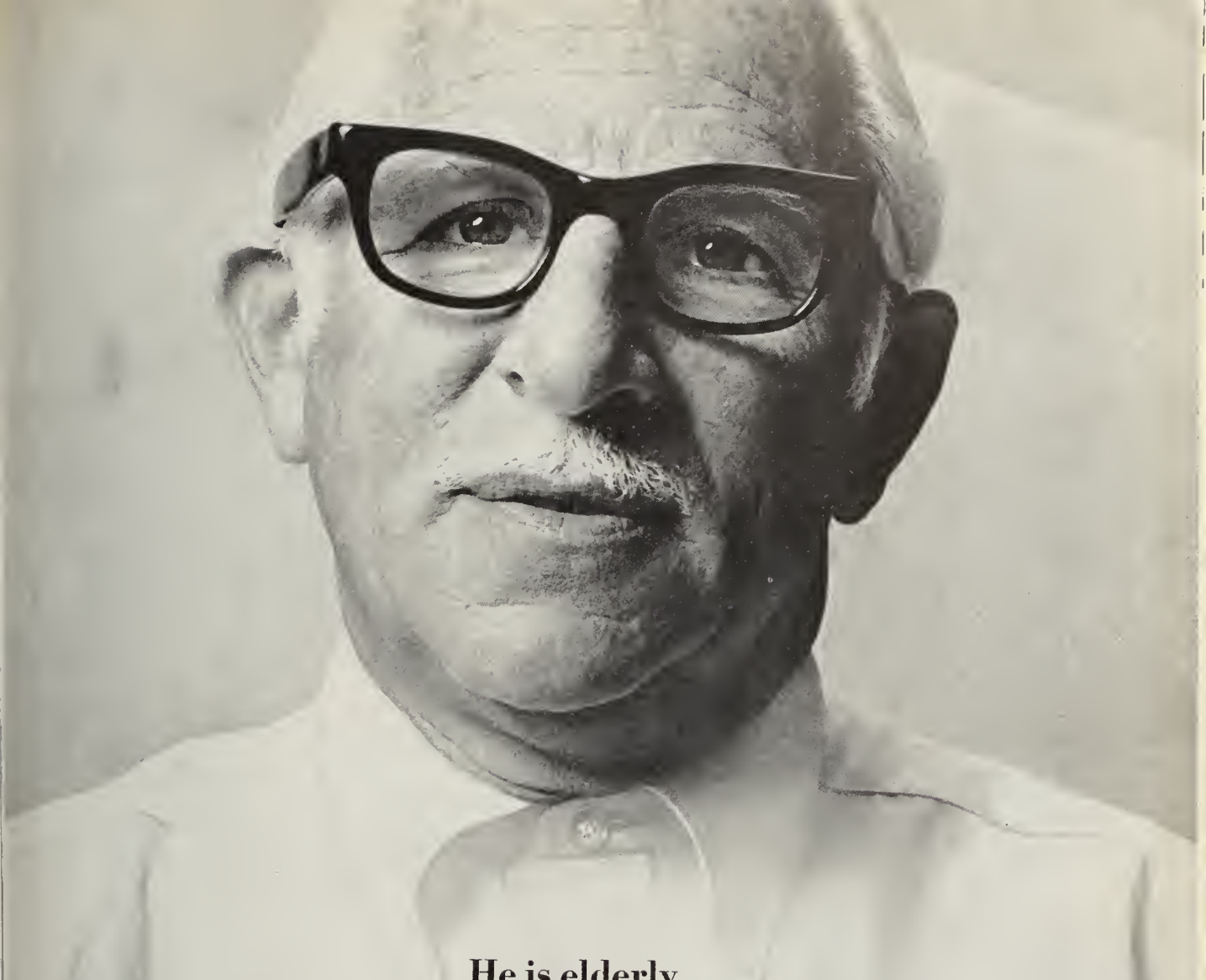
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cautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Emergency Health Services Digest Available

The response to the first issue of a new HEW periodical, *Emergency Health Services Digest,* by a test group of physicians and other professionals has been so favorable that the publication has been released for distribution to all interested in emergency services, the HEW announced.

Published by the Health Services and Mental Health Administration's Division of Emergency Health Services, the first issue contains summaries of 57 articles selected from current professional literature. Each article deals with some aspect of planning, programing, training or delivery of emergency medical and health services.

The *Digest* is available from the Public Information Office, Division of Emergency Health Services, 6935 Wisconsin Avenue, Chevy Chase, Maryland 20015. It may be purchased from the U.S. Government Printing Office, Washington, D.C. 20402, at 40 cents per copy.

Cincinnati Environmental Research Project Supported

A University of Cincinnati Medical Center team studying the mechanism of cadmium toxicity has received a boost in its research by a $1115,575 three-year grant from the U.S. Public Health Service Environmental Control Administration.

The project is headed by Associate Professor H. G. Petering, of the environmental health and biological chemistry services, in collaboration with Leslie M. Klevay, M.D., assistant professor of environmental Health and instructor in medicine; and Klaus L. Stemmer, associate professor of environmental medicine and instructor in pathology. Dr. Petering also is supported by a two-year grant from the American Medical Association's Educational Research Fund.

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The Needs of Continuing Education

From the Standpoint of a Hospital Administrator

By J. Russell Shawver, Kettering, Ohio

SOME TIME AGO, a famous cosmetologist made the statement, "I can tell within two years when a woman graduated from school, and from which part of the country she grew up, unless she has had the assistance of a beauty consultant." How could he hope to do this? He claimed the way women apply their make-up and style their hair changes very little from that particular time in life.

Since having heard this theory on the habit patterns of the fairer sex, I have engaged in some observations on my own, I believe they call it girl-watching in the gone generation, and I have been amazed at its accuracy.

The real question for today is, can you tell the year of graduation from medical school and the part of the country for the physicians on medical staffs? There is little doubt that a significant number are practicing on approximately the same level as when they completed their formal education, ten-twenty-thirty or more years ago.

The state of the art of medical sciences is totally different than it was just ten years ago, or at least should be if the people are to get the benefit of the advances that have been made. This situation is hardly compatible with the moral and legal responsibilities borne by trustees of progressive hospitals and their man-on-the-job, the administrator, to assure the highest quality of patient care feasible within the economic resources.

Concern of Hospital

Therefore, it is a legitimate concern of the hospital to encourage an effective continuing education program for its medical staff.

The busy physician who wants to keep up to date has long stood with one foot in quicksand and the other in quagmire. If he's overinvolved in continuing education, his practice suffers. If he's underinvolved, his patients suffer. An *Ohio Family Physician News* article recently summed up the problem neatly when it listed four questions that good family doctors regularly ask themselves: "How can I keep up? What is new that I need to know? How can I possibly go to all the scientific meetings I need and still not leave my patients without help? If I take time off to go to a meeting, will it be a waste of time?"

Yet, as a direct paradox, this same physician is caring for the most sophisticated public ever to face a follower of Hippocrates. Kept relentlessly up to date on the latest medical development by reading the *Reader's Digest* and the *Ladies Home Journal*, his diabetic patient is very likely to ask, "What do you think of that new technique for urine sampling?" a situation he very likely hasn't heard about.

Formidable Problem

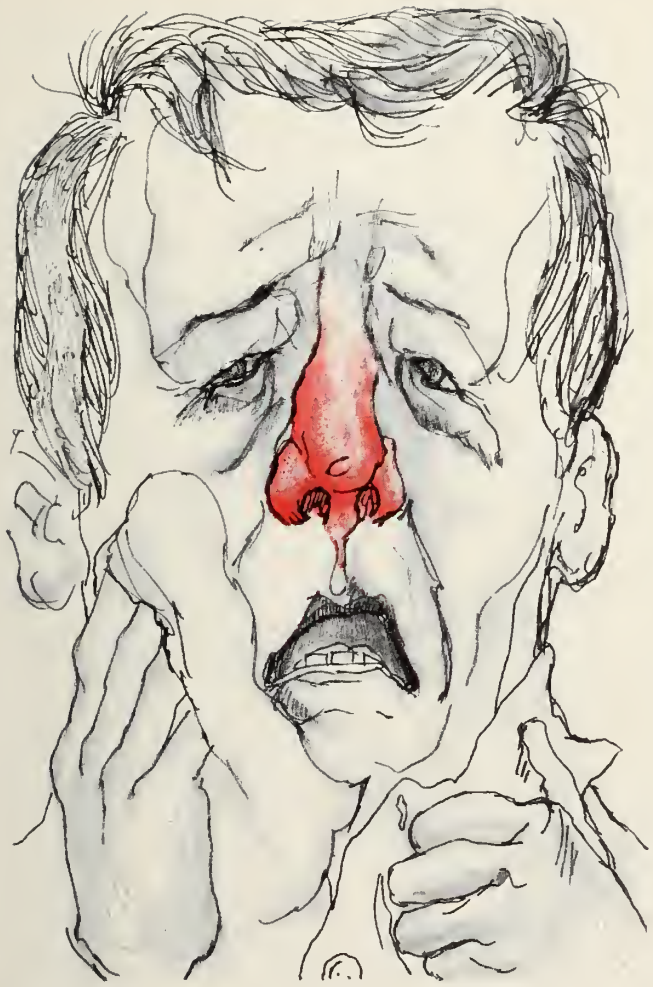
The problem is formidable. In our dynamic, technologically oriented scientific society, it is estimated that each year more than 250 million pages of new scientific information are published. Scientific knowledge is now doubling in less than every ten years, and a physician would have to read the equivalent of a 500-page textbook every day to keep up. One radiologist estimated that to stay abreast of his specialty alone would mean reading a minimum of five books a week. When will a busy, concerned, committed physician do this—between office visits? enroute to the hospital? over breakfast? by the light of "midnight oil" when everyone else is asleep or having fun?

Perhaps he should take a little time off each year to attend some postgraduate conferences. There is plenty of opportunity because there has been great increase in the number, variety and quality of short postgraduate courses offered. Many are taking advantage of them for there have been impressive gains in the number of registrants. In the year 1965-66, there were 1,641 postgraduate courses in the annual list of the AMA Council on Medical Education. They were offered by 252 primary sponsors, with 53 per cent sponsored by medical schools and 21 per cent sponsored by hospitals. The number of courses has increased almost 50 per cent in the past five years, and the number of registrants has increased more than threefold.

Critics Still Find Fault

Impressive as this may seem, critics find many faults with our postgraduate offerings. They claim them to be archaic, inappropriate, and ineffective. They primarily rely upon lectures, a

This article is the transcript of a talk given before the OSMA Section on Directors of Medical Education's Fourth Annual Workshop held in Cincinnati, December 3, 1969. Mr. Shawver is Administrator of the Kettering Memorial Hospital.



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The Common Cold, January AMA
December 23, 1963

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method largely abandoned in undergraduate medical education because it has been demonstrated time and time again that retention of material from lecture is generally poor. Subject matter and presentation may not be pertinent to the practicing physician's needs or interests and may actually be contrary to his experience, creating a professional credibility gap. The curriculum is usually fragmentary, having been farmed out to various experts who didn't know what the others would be covering, and therefore, lack continuity or make for boring duplication.

And, while the physician is gone, who is going to care for his practice? In a survey conducted by the AMA, eight major deterrents to attending continuing education courses by the practicing physician were found:

1. No one to care for his patients while he is away;
2. Courses held at unsuitable times;
3. Cost in money and time away from practice is prohibitive;
4. Multiplicity of other meetings;
5. Subject matter not suited to the physician's needs;
6. Lack of courses in the physician's area;
7. Previous unsatisfactory experience with poor courses; and
8. Lack of information about courses.

And I am sure they omitted that the poor devil is tired. At any rate, such educational interludes or episodes in themselves do not seem to meet the basic educational needs of busy practicing physicians.

Other Methods Tried

Other means and devices utilizing great ingenuity have been tried with varying degrees of success. There is a very capable wife who scans the literature and brings her busy husband up to date, or tells him what to read each morning at the breakfast table. Some medical librarians find pertinent articles, either on their own initiative or upon request, to bring to physicians.

There have been efforts with two-way FM radio, telephone and closed circuit television conferences, but a casual visit to the physicians' lounge when these things are happening doesn't cause fear of being trampled by the stampede. Albany Medical College is equipping jukeboxes with 80-six-minute records of instruction, and trying to decide whether or not to charge a quarter to hear them. Tape recorders for cars and joint medical society meetings, and countless ideas are being attempted to coax the busy physician to continue his education.

There are three basic criteria which must be present for an effective continuing education for the practicing physicians:

It must be continuing in order for it to become habitual, a way of life.

Since the majority of the physician's practice is in the community hospital, hospital practice becomes the medium that must be used.

And, it must be directly related to the physician's day-to-day activities in the care of his patients to achieve involvement.

Two programs which can fill these three conditions are a medical audit-utilization program, and a quality intern-resident program.

Medical Audit Effective

The medical audit utilizes the physician's own patients and his own experience and, therefore, he is directly involved. By utilizing the self-education principle, it stimulates him to seek knowledge on his own initiative. All members of the staff are involved because all of the patients are reviewed and, though he may not read the literature or go to meetings, he will not be able to escape the impact of a rotating committee reviewing his patient management.

Being faced by one's own errors is usually sufficient motivation to seek formal assistance from the library or a consultant. Areas of greatest need are uncovered by the audit committee, making it possible to plan programs or meetings that will provide greater assistance to more of the staff members.

Even the smallest amount of activity revolving around the audit mechanism will result in better patient care, which ultimately is very strong motivation to all physicians, and it can be utilized in any hospital regardless of size or proximity to a large medical center. There can be little doubt that the internal medical audit is a very effective educational tool, which is, unfortunately, very seldom used to its potential.

The second program revolves around an aggressive intern-resident program. It has been stated that the most powerful force for the continuing education of the medical staff in the private hospital is the extern, the intern, and the resident. No planned program of lectures, conferences or films can inspire continued learning by staff members equal to the stimulus set in motion by an intern or resident who is a potential source of searching and revealing questions.

Staff Changes Produced

It not only acts as an educational stimulus but also produces fundamental changes in staff

organization, policies, and procedures. Medical staff standards are constantly raised to satisfy the evolution of a good training program, to provide a point of common interest for staff members and to produce effective pressure upon marginal practices.

The evolution of a dynamic program usually includes the appointment of a director of medical education, the establishment of a planning and coordinating Educational Committee of the medical staff, and the selection of a teaching staff or panels. This activity can be infused into the various departments as ways to improve the care. The need for coordination of the staff departments to harmonize with the objectives and activities of the educational procedure may result in the director of medical education being included in the nominating committees.

Eventually, the recruitment of geographically part or full-time salaried service educational coordinators for the busiest departments will result in a closer relationship with nursing, attending, and house staffs. In cases of bed shortages, the admitting policy may be revised, giving higher priority for those physicians who are involved in the teaching program. Staff bylaws and regulations will be revised to buttress the educational functions, and concerned and motivated physicians will constantly be on the alert to guard against house staff being used for "scut" work. In these and many other ways, the needs of the medical education program tend to raise the standards of the medical staff and to stimulate a progressive and dynamic atmosphere within the hospital.

From the Latin, "doctor" means "teacher." By being a teacher, the physician improves himself. By dedication to medical education, the medical staff organization similarly improves, and the entire hospital, and ultimately the patients, benefit.

Cost Factors Involved

You would probably be disappointed if an administrator did not mention the cost of education, for the intern, the resident, and for the medical staff. There has been much discussion about how the house staff has been exploited, and there is some substance to support these feelings. In a recent study it was discovered that interns worked from 51 to 133 hours per week, residents from 38 to 123 hours per week, and the average for all house staff was 79 hours per week, about twice the 40-hour work week considered to be standard for most employed persons. Typical stipend was $4,300 which, in 1969, clearly is only a subsistence amount. Yet the cost to the hospital for maintaining the program ranges up to seven percent of the operating budget and amounted to as much as $2.30 per day per patient. In the past, the hospital has typically borne the cost of educating many of its specialized professionals. Schools for nursing, for x-ray technicians, and for laboratory technicians are typical examples. The current trend is to move these educational functions out of the hospital into educational institutions, and to transfer their cost from those paying the hospital bill to the student, and the community at large, which supports the schools. There have been charges that students also were a source of cheap labor. Yet the other side of that coin leads to the natural conclusion that they should contribute to the patient care that was supporting the cost of their education, since they were paying minimal amounts, if anything, for it.

Hospital Is Training Center

There is probably no place other than the hospital where physicians can be trained, although some feel the community hospital should leave such training to the university hospitals which from certain aspects may be better qualified. The trustees and administration of a hospital must ask this question, "How many of the patient's dollars can we justify to ourselves and to those who are taxed for supporting the training of physicians, present and future?"

It is very unpopular to ask the attending medical staff to support the educational program, because they are called upon to support so many other things in the community, and they give generously of their time in the training.

There have been suggestions that insurance carriers, recognizing that medical care is better in hospitals with aggressive teaching programs, are increasingly willing to absorb a portion of the cost. This may happen in isolated, specific situations, but it is not generally the case. Because of the rapidly rising cost of hospital care, most third-party carriers seem reluctant even to pay for better patient care.

Hospital auxiliaries have been suggested as sources of funds for medical education. Although they should be given much credit for their contributions to hospitals, they seldom raise enough to provide much of the operating costs of such a heavy expense. When they do present the hospital with a gift, usually it is a piece of equipment on which they can put a plaque.

Another potential source of support usually considered is affluent patrons or patients who may establish trusts or endowments for graduate medical education. However, with the chronic shortage of beds and supporting services, most gifts are directed toward new wings—which also seem to

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Serum Potassium Levels (in mEq./L)

Number of patients	Mean initial value	Mean final value
14	3.23	4.83
16	3.50	4.40
25	4.52	4.47

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Administration and Dosage: K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement.

How Supplied: Effervescent tablets—boxes of 30 and 250 (orange or lime).

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have more appeal to donors. Current tax laws, and the proliferation of worthy causes, have caused a virtual drying up of this source of income.

Acceptable Method Needed

Somehow, an acceptable method must be found of charging for the actual professional service rendered by the house officer or service chief to provide a means of support for the educational program. A nonprofit foundation could be established to collect for such services and to pay the stipends of the interns-residents, the salary of the directors of medical education and service educational coordinators, and the cost of speakers, films, and other supporting material.

Such a program is being used at the Mayo Clinic. Before this can happen, however, the rank and file attending physician will have to get over the kick that professional fees are somehow hallowed and his feeling that it is unethical for those fees to be used for anything other than becoming his income.

To summarize, the physician is a very busy fellow and, although he wants to keep up, continuing education must basically be an on-going program, built into the program of the local hospital where he practices, and must become as much a part of his life as is completing his medical records. Two programs that can accomplish these objectives are an effective internal medical audit program and an aggressive intern-resident program. While an audit committee can be effective in any size hospital in any geographical location, seldom are they really viable. Only larger hospitals (considering that the typical hospital in the USA is closer to 100 beds) are able to provide a postgraduate program, and no really good mechanism exists for supporting them when they do exist.

Hospitals Must Review

Hospitals must take a fresh look at their objectives and review their services. It must be determined if they are actually fulfilling their responsibilities to the people in the community and to physicians, who wish to move off a plateau of mediocrity and to go all-out for excellence. Administrators and governing boards must help medical staffs develop self-government into a positive, constructive, and statesmanlike force in the hospital.

Physicians must be more closely involved in policy and decision-making, and must learn to understand hospital economics. Physicians need to understand the relationship between good management and good patient care, learn to accept other professionals on the health-care team, and remember that there are more things in ethics than dollars.

At the present time, our whole health care delivery system is being challenged. Therefore, we must work together to provide the kind of care that will make management control from outside unnecessary.

Heart Abstract Deadline Announced

June 5, 1970 is the deadline for abstracts of papers and applications for scientific exhibits and cardiovascular films to be considered for presentation at the American Heart Association's 1970 Scientific Sessions. The four-day meeting is scheduled from Thursday, November 12 through Sunday, November 15 in Atlantic City, N.J.

Papers intended for presentation must be based on original investigations in the cardiovascular or related fields. The project's results and the investigator's conclusions should be summarized in the abstract and submitted on official AHA forms.

A full day will be devoted to the showing of cardiovascular films. The Association's Subcommittee on Films will select recently produced prints for presentation.

Official forms for submitting abstracts, films and scientific exhibits may be obtained from the Department of Medical Education at the Association's National Office, 44 E. 23rd St., New York, N.Y. 10010; or through the Ohio State Heart Association, 10 East Town Street, Columbus 43215.

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When it comes to preventing baldness, researchers have been drawing blanks for thousands of years.

The first known medical record, the Ebers papyrus (written about 1500 B.C.), contains a prescription to correct loss of hair.

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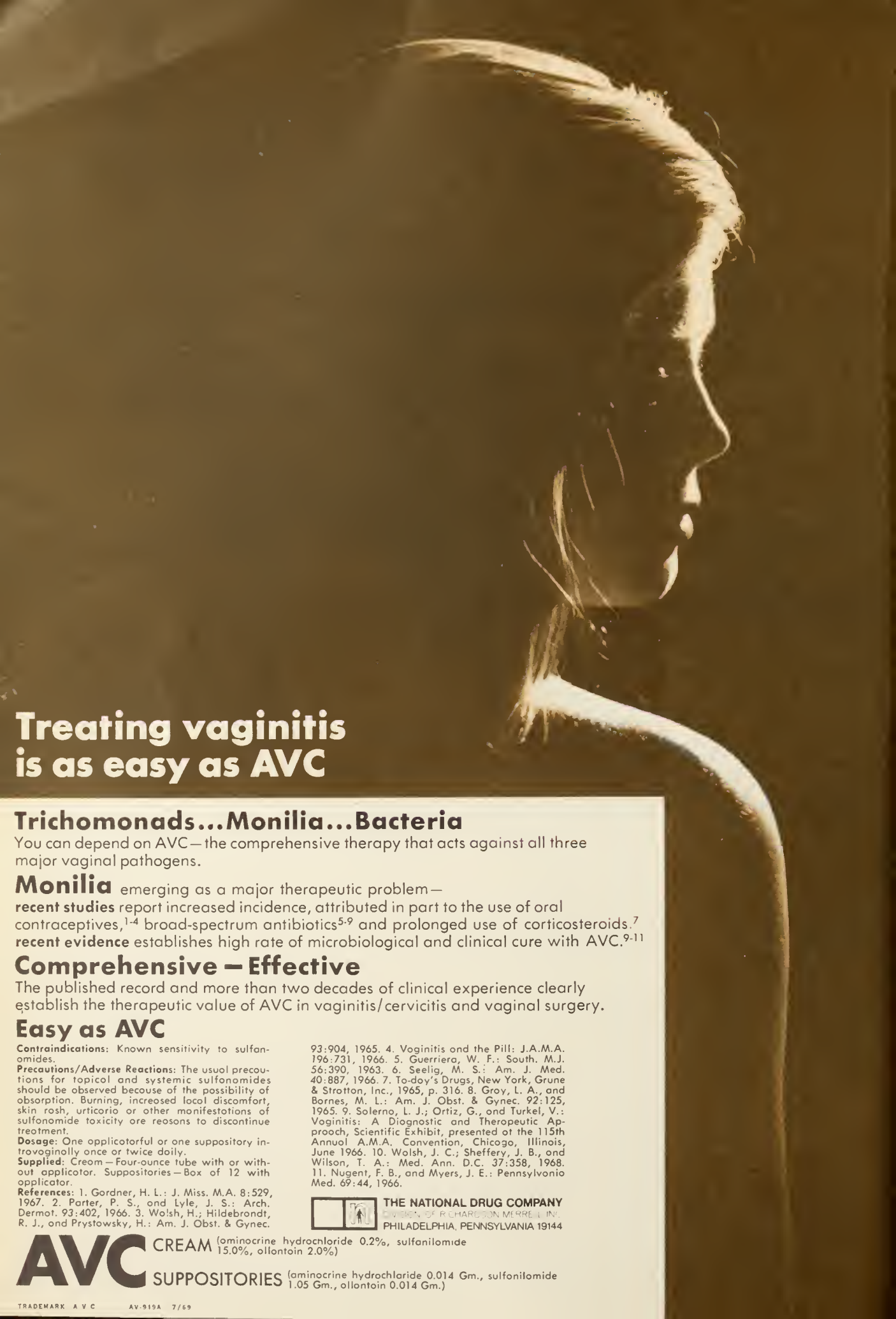
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Teacher and Physician --- Partners in Promotion of Healthy Citizenry

By I. C. Sharon, M.D., Cincinnati

THE TEACHER AND THE PHYSICIAN have always had many things in common, and better general interdisciplinary communication in recent years, fostered by rapid technological advances, have brought them closer together. The teacher shares with the doctor a well-defined authoritative role and also a subtle, non-authoritative role of friend, listener, and counselor. This latter role helps to extend and enrich the child's experiences in the home situation and promotes values to the overall educational process. It also takes into account the needs and motives of the child.

In addition to their knowledge, both teacher and physician need their expertise and overall personality to achieve a high degree of effectiveness. This implies an understanding of behavioral science, an ability to demonstrate mature judgment, a capacity to cope with emotional stress, and the possession of certain personal qualities such as sincerity, honesty, and a sense of dedication. Teachers and doctors need insight into their own emotional hangups so as not to impose their own shortcomings upon those whom they are trying to help. They should have some understanding of family dynamics and how family conflicts can arise.

The physician has become more mindful of his role as a citizen and has become more interested in social and economic factors especially in relation to preventive medicine. He recognizes symptoms of environmental unrest in the form of headaches, stomach complaints, obesity, tiredness, and apathy. He is becoming more involved with behavior and learning disorders and is becoming more aware of their precursors—prenatal and perinatal influences, unbalanced chromosomes, insecurities of infancy and early childhood, poverty, malnutrition, and physical impairments. He has become more concerned with the roots of disease and disability rather than merely dealing with symptoms . . .

Health education should be integrated into the curriculum of both the elementary and the secondary schools. This should include information and discussion on such topics as nutrition, sex, smoking, alcohol, mood-influencing drugs, and principles of physical and mental hygiene. This teaching could profitably be extended to the parents. Guidance for any controversial material could come from committees composed of parents, physicians, teachers, clergy, and school administrators. Health education should naturally and rightfully begin at home, but even when parents are mature and knowledgeable, it is difficut to overcome the psychological barrier between child and parent to achieve effective communication. Parents are too prone to preach and moralize.

It is hoped that the Public School System will take advantage of our large medical center and invite physicians to participate in many of its deliberations and undertakings. Effective cooperation between the teaching and the medical professions can do much toward making better, healthier, and happier citizens and a finer community.

★ ★ ★

Are We Doing Enough in the Area of Prevention?

Public health measures, industrial safeguards, and immunization practices have done much to prevent disease and disability. But the incidence of our chronic diseases is on the increase.

It should be the responsibility of the medical profession through health education to stress what the individual himself can do to prevent or retard many of the degenerative diseases, prevent excessive bodily wear and tear, and promote creative health and longevity.

In addition to encouraging periodic physical examinations, the medical profession must take the

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Background of This Article: At the request of the Academy of Medicine of Cincinnati, Superintendent Paul A. Miller, of the Cincinnati Public School system, contributed an article that appeared in the *Cincinnati Journal of Medicine*. Encouraging intercommunication between the medical and educational professions, Dr. Miller suggested that a member of the Academy contribute an article to *Schools in Action*, publication of the Cincinnati Public Schools. The accompanying text is based on the article which appeared in the January, 1970 issue of *Schools in Action*. Dr. Sharon is Public Relations Editor for the *Cincinnati Journal of Medicine*.

initiative in providing knowledge concerning the preventive aspects of chronic diseases. Emphasis should be given to such topics as proper diet, recent advances in nutrition, principles of mental hygiene, exercise, cancer detection, and hazards of obesity and smoking.

Physicians should take every opportunity in their professional contact with patients to impart knowledge along lines of preventive medicine. Much can be done during the annual physical examination, but the emphasis here is on the detection of early disease and disturbed function and unfortunately time is not available to get into any depth on prevention. Furthermore, this one-to-one relationship is too time consuming, does not get to enough people, and lacks the stimulation ordinarily generated in the interaction of a group.

Council of the Academy of Medicine of Cincinnati has recently approved the promotion of Health Education on an ongoing basis through lectures, forums, and courses. It is hoped that more and more physicians will get involved. — I. C. Sharon, M.D., Public Relations Editor, *Cincinnati Journal of Medicine*

Dr. Sabin Heads Search for Human Sarcoma Virus Link

The National Cancer Institute, National Institutes of Health, has embarked on a worldwide search for isolated groups of people with special genetic constitutions, from whom scientists can obtain tissue specimens to aid in the identification of viruses that may cause human cancer.

Dr. Albert B. Sabin, one of the scientists responsible for the eradication of poliomyelitis, now studying the virus-cancer problem, is directing an Institute-supported project to detect a human sarcoma virus. The noted virologist, for more than 30 years at the Children's Hospital Research Foundation, University of Cincinnati, is trying a new and unique approach in the search for a human virus that might be comparable to the sarcoma viruses of chickens, mice and cats.

Dr. Sabin plans to develop about 100 tissue culture cell lines derived from population groups that are highly isolated, either socially or geographically, in the hope of finding cells that are both genetically receptive to and at the same time free of cancer viruses.

Extracts of 80 human sarcoma specimens of bone and soft tissue obtained from surgical patients are concentrated by centrifugation, then placed on the cell cultures. Each culture is watched for a "focus," or an outgrowth of a small number of transformed cells into little tumors, the presence of which would indicate the existence of a human sarcoma virus transmitted from the tumor extract to the cell culture. If no "focus" appears, all the cells are subcultured to detect any outgrowth of transformed cells that may have been missed in the cultures initially exposed to the sarcoma extract. It is this procedure of subcultures that adds a tremendous amount of labor to the project.

The tissue specimens for starting the culture cell lines are pieces of skin, each smaller than a pea, obtained by biopsy. The biopsy process is painless and easily accomplished with the aid of a punch device and a local anesthetic.

It is important, National Cancer Institute scientists point out, to obtain the skin from isolated peoples who hopefully may not have been exposed to the special viruses that are the targets of the studies. Several specimens have been obtained from a few population groups, but it is expected that many more will be collected in the near future.

The Havasupai Indians, a tribe that has lived by itself on the floor of the Grand Canyon for ten centuries, cooperated by producing 18 volunteers in on afternoon. Twenty-one residents of the island of Saba, in the Netherlands Antilles, east of the Virgin Islands, offered to give skin samples. These people, fishermen of Dutch ancestry, number about 1100, but there are no more than four or five family names on the island.

The Samaritans of Israel, socially isolated from the rest of their compatriots since biblical times, have volunteered to participate. In Sappada, a community of people of German descent in the Italian Alps physically isolated from their neighbors by rugged mountain terrain since the thirteenth century, one person has volunteered so far, and the investigators are hopeful more will do so.

Other suitable population groups will be approached in the hope of obtaining cooperation in the project. Some of the groups are the Apache, Pima, and Hopi Indian tribes of Arizona; a community of French people on St. Thomas, Virgin Islands; Hawaiians from the outer islands; the tribes of West Africa; and the insular residents of Tangier Island, in lower Chesapeake Bay.

EDITOR'S NOTE: The foregoing announcement was made by the National Cancer Institute before Dr. Sabin left for his appointment with the Weizmann Institute in Israel. This international search is only one of a number of research projects both in this country and abroad receiving the active support of Dr. Sabin.

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Side effects: May cause flushing, feeling of warmth, Rarely Papaverine may cause drowsiness, anorexia, malaise, headache.

Precaution: Use with caution on patient with glaucoma.

Caution: Federal law prohibits its dispensing without a prescription.

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Dunlop[2] **on Cerebral Ischemia:** "Even in patients in whom the cause of symptoms is in doubt, Papaverine merits consideration as a therapeutic trial. The occasional favorable response in such instances is most gratifying."

Stern[3, 4, 5] **on Peripheral Ischemia:** Substantial relief of the symptoms typical of peripheral vascular disease was demonstrated in three double-blind cross over studies covering 80 patients. A total of 73 patients reported mild, good and excellent symptom relief.

Various Nicotinic Acid Derivatives and Their Hypotensive and Vasodilation Effects. Ruggieri, R. in Giornale bi Medicina Militare, Vol. 107, Sept. to Oct. 1957, pages 460-2.

[2]**Dunlop E.:** Chronic Cerebral Vascular Insufficiency Treated with Papaverine, Geriatrics Soc. (accepted for publication).

[3]**Stern, F.H.:** Papaverine in the Treatment of Peripheral Vascular Disease, J. Am. Geriatrics Soc. 13:815 (Sept) 1965

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To Strengthen Specialty Ties

THE American Medical Association established a new headquarters staff department recently to strengthen liaison and services to related medical organizations. It is the Department of Speciality Society Services, reporting directly to Richard S. Wilbur, M.D., assistant executive vice-president. Department Director is Theodore R. Chilcoat, Jr., a five-year staff member formerly assigned to the AMA Washington Office.

The Department will serve and implement the directives of the Interspeciality Committee which was created in 1966. On the same date, Ernest B. Howard, M.D., AMA executive vice president, announced that Doctor Wilbur was appointed secretary of the Committee, succeeding Hugh H. Hussey, M.D., who was appointed director of the AMA Division of Scientific Publications and editor of the *Journal of the American Medical Association* January 1.

Commenting on the new appointments, Doctor Howard said, "The establishment of this special department is an important step in strengthening AMA's relationship with the specialty societies, and it is the culmination of a long range program undertaken to upgrade the services of the AMA to the specialty societies.

"After the founding of the Interspecialty Committee, the House of Delegates appointed an Ad Hoc Committee to Study the modus operandi of the Sections of the House of Delegates. Its report, prepared under the direction of its chairman, William F. Quinn, M.D., a Los Angeles surgeon, called for the creation of a group of section councils to provide specialty societies with direct representation in the AMA House of Delegates. The report was adopted in July, 1969.

Its specific recommendations were to:

- Establish a mechanism for stimulating increased cooperation between the specialty medical societies and the AMA, thus forging a relationship that will bind specialty societies and the AMA closer together, generating a singleness of purpose which will benefit all of medicine;
- Give more satisfactory representation in the House of Delegates to the specialty organizations;
- Provide for an increase in experience and competent manpower to assist the Council on Scientific Assembly in developing the Association's Annual Convention scientific program;
- Generate stimulating and engaging interdisciplinary and specialty-oriented programs which will command the interest of greater numbers of practicing physicians;
- Provide a direct and continuing liaison between a section and its corresponding specialty societies;
- Permit specialty societies direct access to the House of Delegates through their appointed delegates, and;
- Give AMA specialty sections recognized status by identifying them directly with the specialty societies.

The Department's responsibilities, under the direction of Mr. Chilcoat and a staff aide, are to assist Doctor Wilbur in his secretarial services to the AMA Interspecialty Committee, further liaison with specialty groups, and advance the development of the section councils of the House of Delegates.

What To Write For . . .

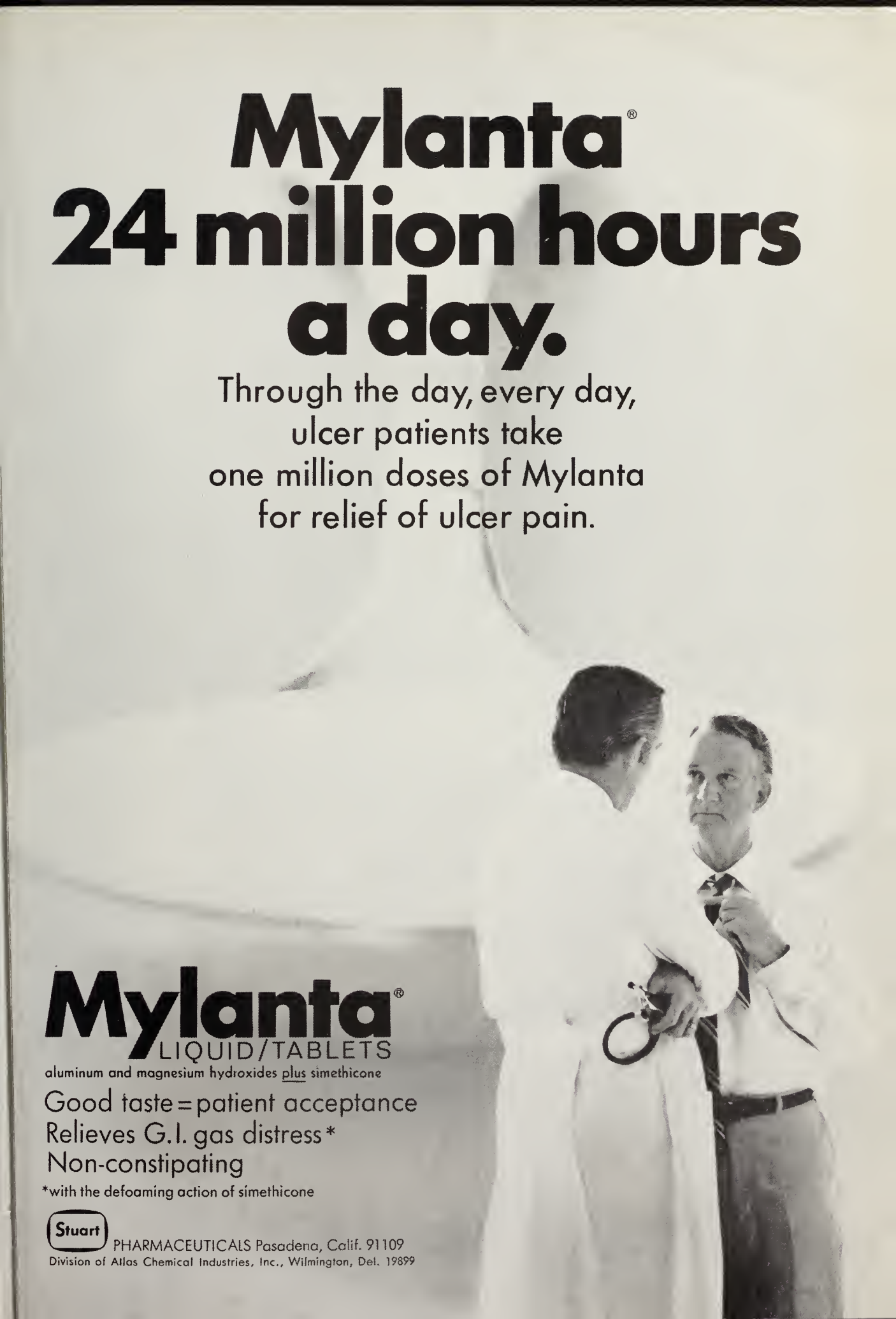
The Short End of the Stick: Annual report of the Arthritis Foundation, being a frank discussion of arthritis, how many are involved, the role the foundation plays, statistical data on the foundation, etc. The Arthritis Foundation, 1212 Avenue of the Americas, New York, N.Y. 10036.

Cigarettes — America's No. 1 Public Health Problem, by Maxwell S. Stewart. This is Public Affairs Pamphlet No. 439 and is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016. The pamphlet is written for the lay public and produced by the nonprofit educational organization.

The Many Faces of Health Education: A pamphlet type catalog with individual descriptions of the pamphlets, posters, books, and other health education materials available through the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610. Price list of the various items is included.

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Government Grants Add More Doctors But Not Private Practitioners

FOLLOWING IS THE TEXT of an entry in the *Congressional Record,* December 16, 1969 (H 12543), containing the remarks of Representative Samuel Divine, of the 12th Ohio Congressional District, and a letter from a Columbus physician.

* * *

DOCTOR SHORTAGE

(Mr. DEVINE asked and was given permission to extend his remarks at this point in the RECORD, and to include extraneous matter.)

Mr. DEVINE. Mr. Speaker, the Congress has program after program designed to provide funds to encourage more medical students, build more medical schools, and ultimately attract more qualified people into the medical profession.

Unfortunately, all of the public money, and good intentions are not solving the problem or the shortage.

A highly respected and able physician in my district, Robert C. Kirk, M.D., recently put his finger right on the heart of the problem — he is an eminent cardiologist. His letter should give some real second thoughts to those of us responsible for providing solutions to these serious problems, as well as those research-oriented people that deplete the ranks of the prospective general practitioners.

Dr. Kirk's letter follows:

COLUMBUS, OHIO,
December 1, 1969

Representative SAM DEVINE,
House of Representatives,
Washington, D.C.

HONORABLE SIR: You are going to be bombarded by the most persuasive men in American Cardiology to keep up and increase the money spent on Cardiovascular Research, probably with the threat if you don't we will all die of heart disease. Personally, I prefer that to cancer or degenerative old age, but no matter. I am writing as a cardiologist associated part time with a University for 35 years. I am Chairman of the Heart Task Force Committee of the Ohio State Regional Medical Program. I am in active private practice, and I am a concerned and aware member of our citizenry.

I am convinced that the more money available to medical research, the more jobs will be opened and taken by promising young physicians who see in this a chance to be another Harvey or Pasteur. I doubt if one out of one hundred will make an actual substantial contribution to new knowledge. I seriously doubt the wisdom of hiring anybody who will take a job in hopes that somehow he will be a Nobel Laureate. In the last twenty years the medical schools have increased their enrollment by 15,000 doctors over and beyond their previous graduates. It is no coincidence that in the same time there have been added to the faculty of these medical schools, 11,000 new full time men — so the net gain to the private practice has been peanuts.

The vast majority of that money for increased enrollment came from the U.S. government. So they didn't get what they paid for. The only way I see to increase the men and women going into private practice is to stop subsidizing every Health Program anybody can think up, and I include the National Institute of Health and the Regional Medical Programs, thus decreasing the choices available to our medical graduates. Nearly every one of them intends to practice, but by the time they get attached to the coat tails or full time research-oriented teachers, private practice gets downgraded or basic knowledge is questioned to the place where they don't dare go "out in practice."

Ask you own doctor if this sounds phony to him, and then vote as your judgment dictates.

Sincerely,

ROBERT C. KIRK, M.D.

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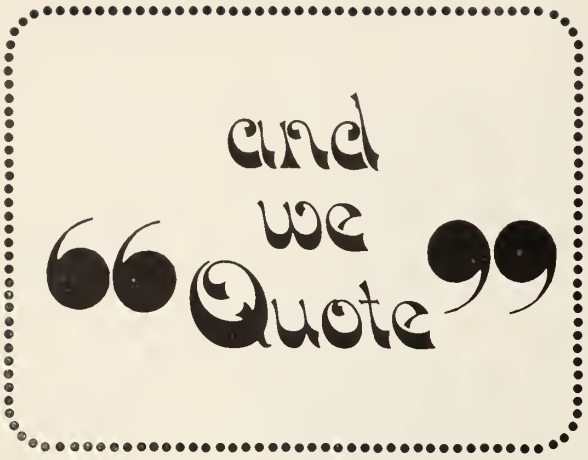
PRESCRIBING INFORMATION. For complete information consult Official Package Circular. Tet. Comb. 1-7/17/67. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms. *Contraindications:* The drug is contraindicated in individuals hypersensitive to tetracycline. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimeter of pregnancy, neonatal period and childhood). *Precautions:* Mycotic or bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 4 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dose:* 1 Gm./day in 2 or 4 divided doses. Continue therapy for 10 days in Group A Beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals. *Supplied:* Capsules—250 mg. in bottles of 16 and 100. bidCAPS—500 mg. in bottles of 16 and 50.

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More Backlash on the Cyclamate Ban

"Before the results of scientific experiments can be accepted as conclusive several criteria must first be satisfied. One is that the experiments should be reproducible in the laboratory of the original authors and by independent investigators. Then the agent in question should be tested in other animal species and other biologic systems to determine whether the results are species specific or have broader biologic significance. To test the specificity of the agent, controls should be injected or implanted with other materials in a parallel manner to the agent being investigated. Furthermore the results must be analyzed in statistical terms which generally mean large scale experimentation. If positive results are obtained, basic research should be conducted into the mechanism of action of the substance. Finally epidemiologic data should be collected in prospective and retrospective studies to determine whether any undesirable effects have been produced. Epidemiologic information is especially pertinent to the cyclamate question since millions of Americans including pregnant women have consumed vast quantities of this compound." — *Connecticut Medicine,* December, 1969.

The Youth of Today— They May Be Your Salvation

"It was reported that you could have heard a pin drop at that dinner for five hundred as he (Governor Ronald Reagan) drew similarities between our day as we begin our third century and the beginning of the third century of ancient Rome. Quoting from historians he told how in the third century of that great Empire the young men began to avoid military service, wore their hair long like women and dressed in effeminate clothes so that it became difficult to tell the sexes apart. He described how sex morals declined and it became unsafe to walk in the streets of Rome, and how deficit spending continued with copper replacing silver in coins.

This makes one think, doesn't it? As you go about your daily tasks what extra efforts are you exerting to avoid the possible inevitable day this country faces, or at least postponing it? How close are you as a physician to the youth of the land? How frequently do you talk to them patiently and understandingly? Is doing so your responsibility and are you willing to accept it? If so, do not ridicule nor criticize them. Try to understand, be patient, gain their respect, and guide them along their way. They may be your salvation." — Lenox D. Baker, M.D., in the *Southern Medical Journal.*

The Golden Rule and the Right to Die

With advances in modern medicine we now have means to keep people living artificially . . . I know cases where people have been kept alive in a decerebrate condition living like vegetables. Is this prolongation of life or prolongation of death? To me this is prolongation of suffering, pain and death. One of the essential duties of the physician is to relieve suffering and pain. There are instances where this can only be done by permitting a merciful death to occur.

So far as I know, no religious groups (Roman Catholic, Jewish or Protestant faiths) say to the physician that he should use extremely extraordinary means to keep life going when death is obviously approaching. A helpful rule for the doctor to follow is *The Golden Rule.* What would the doctor himself want if he were in the patient's condition? — Excerpt from summary of remarks by R. B. Robins, M.D., Chicago, in a panel discussion as printed in *The Journal of the Arkansas Medical Society.*

Sex Education as Character Training

"Sex education must not be restricted to a limited set of anatomic and biologic facts, but rather must be a lifelong acquisition of knowledge about what it is to be a man or a woman. Its purpose is much broader than its title implies. Proper sex education should be looked upon as

character training to make the individual knowledgeable and emotionally healthy, and to instill values and standards that will help make him or her a responsible adult, able to choose a mate with whom a stable and happy marriage can be created and can be maintained.

"Ideally, sex education should take place in the home, but it is well recognized that it is only in the unusual home that it actually is accomplished. Thus there is a need for sex education in the schools. Surely young people should not be denied teaching which will help them become wholesome young adults, possessing the character and the self-discipline that they need if they are to achieve happiness for themselves and to provide it to their children." — *Journal of Iowa Medical Society.*

Nonfragmented Treatment in Continuing Health Care

". . . Major medical decisions must be made with extreme accuracy as well as with great haste by the doctor in an atmosphere of overwhelming daily patient load . . ." (the family physician must care for the whole person and treatment must be) "nonfragmented, administered in a comprehensive and continuing health care system . . ." — Raymond M. Kahn, M.D., Dayton, as quoted in the Newspaper of the National Association of Blue Shield Plans.

In the Profession a Majority Is Not Enough

"We have heard all of the admonitions about what we must and must not do in order to keep a reasonably tight lid on medical care costs. But our first responsibility is, and always will be, to give our patients the best medical care possible. We can no longer take the attitude that there is no problem and that all physicians are honest and pure; to have a majority who are is not enough in our profession." — Russell L. Deter, M.D., in *Texas Medicine.*

Working in Some Kind of Cooperative Relationship

"It is not possible, ladies and gentlemen, for 300,000 physicians in this country, with 200 million population, to completely determine all of the terms and conditions that go into the complex question of medical care, medical schools, medical education and delivery of care, access to care and Blue Cross and Blue Shield and Medicare.

"I think the whole 200 million, including the 300,000 physicians and 650,000 nurses — in fact, all three million of the people working in the health industries, have to be brought together in a new kind of working relationship. I believe that one of the most important suggestions that I can make is that the health professions and the physicians generally seek out consumers of medical care and attempt to work with them in some kind of a cooperative relationship." — Wilbur J. Cohen, as quoted in *The Journal of the Indiana State Medical Association.*

Partial Vacuum in USA Draws Foreign Medical Graduates

The medical schools of the United States have not for some years produced physicians in sufficient numbers to meet the population's demands for medical services. While one part of the AMA is urging that additional schools be built, other factors within the AMA find that the operation of meticulous regulations retards the projected acceptance and opening of such schools.

Into this situation has been drawn the foreign medical graduate . . .

The number of FMGs coming to this country has increased progressively in the last 20 years. In 1966 and 1967, there were 3,336 immigrants who were FMGs, and 5,224 exchange visitors who were FMGs making a total of 8,560. During that same year, the graduates of the U.S. medical schools numbered only 7,743. For the first time, there were more FMGs than U.S. medical graduates.

Not all of the immigrants will remain . . . — *Journal of the Louisiana State Medical Society.*

No Complaining Witnesses in Illicit Drug Traffic

"The objectives of law enforcement (in regard to drug abuse) are to reach the highest possible sources of drug supply and to seize the greatest possible quantity of illicit drugs before use.

"These are difficult goals, given the fact that drug transactions are always consensual. There are no complaining witnesses or victims; there are only sellers and willing buyers. The enforcement officer must therefore initiate cases. He must find and take up positions along the illicit traffic lanes. - - -

"The payoff in enforcement is the "big case" against the major violator with executive rank in the traffic. This man is hard to identify and harder to implicate with legal evidence. He has a shield of people in front of him, and by not handling drugs himself he removes his liability to prosecution under laws that prohibit possession,

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Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

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sale, or other such acts. The conspiracy laws are the most useful weapon against such a person, and over the years many important convictions have been obtained under these laws. - - -"—Joseph M. Arpaio, Deputy Regional Director, Bureau of Narcotics and Dangerous Drugs, Baltimore, in Medical Annals, June 1969.

Some Literary Greats Avoided the Long Sit

Can the art of writing be harmful to your health?

The sitting involved in long hours of writing puts a stress on both mind and body, most medical men agree. And journalists have one of the highest mortality rates of any profession.

But many professional writers have instinctively found a solution to the problem, the Health Insurance Institute relates. A large number of them manage not to sit when they write.

A leading medical magazine reports that many literary giants stood while writing. Others managed to write lying down.

Among the vertical writers:

Ernest Hemingway, Victor Hugo, E. C. Bentley, Thomas Wolfe, Albert Camus, Jules Romains, and "My Fair Lady" stage and screen lyricist Alan Jay Lerner.

The magazine also pointed out that Dr. Benjamin Spock dictated the first draft of his world-famous "Baby and Child Care" while standing.

Some writers neither sit nor stand while working: they stay in bed.

Included among history's noted horizontal writers are:

Marcel Proust, Elizabeth Barrett Browning, Jack London, and in their later years, both Mark Twain and Frank Stockton.

Other famous horizontal writers had no choice.

For instance, John Buchan wrote while seriously ill. Heinrich Heine wrote while partially paralyzed for eight years, and D. H. Lawrence wrote steadily through flare-up of tuberculosis.

The Irish poet Thomas Moore, a confirmed "horizontal" writer, wrote in his memoirs: "It is singular, the difference that bed makes, not only in the facility but in the fancy of what I write."—Health Insurance Institute.

Now We Come to Breathing the Air of Your Choice

"The recent action of the Water and Air Resources Commission in adopting a set of standards for air quality is to be viewed as a start rather than as an ending to the fight for clean air. The standards in general meet the criteria set forth by the U. S. Department of Health, Education and Welfare, and if they are enforced should remove some of the hazards to health from air pollution. The standards, however, cover only particulate matter and sulfur oxides. Serious pollutants such as nitrous oxides, ozone, carbon monoxide and hydrocarbons are completely ignored. Presumably, we are to breathe only that portion of the air covered by these standards." — *Delaware Medical Journal.*

Are We Missing Something with Promised Degree of Fulfillment?

"We take justifiable pride in the achievements of American medicine. This is not to say, however, that we can stop here. Our traditional system of care has worked well, for a good proportion of our people. We would make a dreadful mistake, however, to assume that this is the only way to treat the sick, to protect the well, to research the unknown, and to educate the student. One must not stand blindly on tradition. I believe, then, that our second most pressing responsibility is to look for new methods and better efficiency in getting our devotion and skills to that one objective, the care of all those who need us. This calls for investigation, for trial, and for objective evaluation of any method which promises a reasonable degree of fulfillment of the goal of the profession—the good health of humanity."—Rufus K. Broadaway, M.D., President, Dade County Medical Association, Florida.

Physicians of Ohio Agencies Meet at Athens Center

The Association of Physicians of the State of Ohio held a regular meeting on January 9 at the Athens Mental Health Center, in Athens. Harry Chovnick, M.D., center superintendent, was host for the occasion, and discussed the subject, "Social Psychology of Power."

Mortimer Hacker, M.D., Toledo, president of the organization, presided and spoke on the subject, "Community Alcoholism — Disease, Illness, or Syndrome?"

Dr. Chovnick conducted a tour of center facilities and discussed the new community services associated with the center. Persons interested in contacting the organization may get in touch with Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Avenue, Mansfield 44907.



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PRECAUTIONS: *Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with* BENYLIN EXPECTORANT *should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing* BENYLIN EXPECTORANT.

ADVERSE REACTIONS: *Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.*

PACKAGING: *Bottles of 4 oz., 16 oz., and 1 gal.*

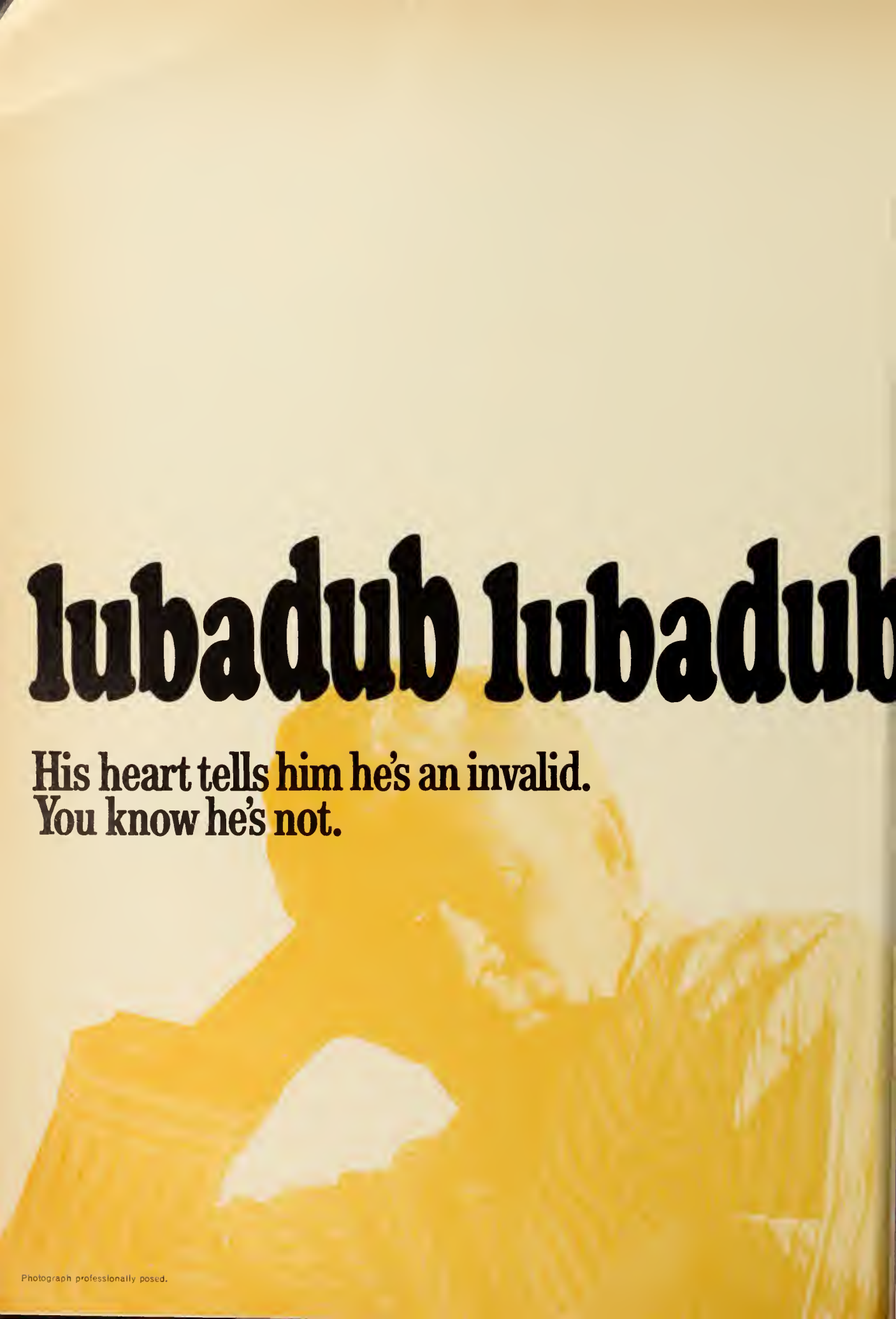
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Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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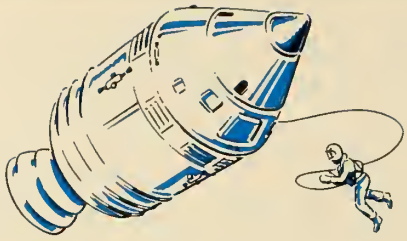
when anxiety is exaggerated . . . when it
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junctive therapy. It helps relieve anxiety
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Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

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Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

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Guest Editorial

The Confirmation in the Laboratory of Observations at the Bedside—Science and Art

The history of medicine is replete with examples of empirical clinical observations transformed into reputable medical advances by the scientist in the laboratory. Such may be the story of emetine—from its use by the Brazilian Indians in dysentery; its specific value in amebiasis; its salutary effects in granulomatous and chronic inflammatory processes; ultimately perhaps as a prototype of a new class of antitumor drugs.

These latter two developments belong to two Doctors Grollman, uncle (clinician) and nephew (scientist).

On May 25, 1969, the Jewish Hospital of Cincinnati dedicated with appreciation its Grand Rounds to Dr. Aaron I. Grollman, former Director of its Department of Surgery, for a particular contribution to Medicine. Doctor Aaron had long ago made a clinical observation suggesting to him that emetine might have significant curative effect in chronic granulomatous and chronic infectious diseases. For several years his persistence and his conviction led to the accumulation of a series of astounding clinical results, reported by him in two articles.

Doctor Aaron encouraged his nephew, Dr. Arthur P. Grollman, then an Associate in Molecular Biology and Medicine at Albert Einstein College of Medicine, to take this alkaloid into the laboratory. The results of the studies by the younger Grollman are printed in this issue of *The Journal*. Emetine has been shown to have an inhibitory effect on protein synthesis in animal cells and amebae, through inhibition of a specific enzyme system; the study of the structure of this drug has led to the design of additional drugs which are potential amebacides; since emetine may have an antitumor effect, it has been accepted for study in certain leukemias and in melanomas by the National Cancer Institute.

Dr. Aaron's interest started in the late 1940's when a dying 23-year-old man with a large unresponsive granuloma of the right lower quadrant of the abdomen pleaded for his life. Despite failure to demonstrate ova or parasites, emetine was started empirically. The fever subsided within ten days, the mass disappeared within two weeks and the patient was known to be fully well 17 years later. About ten years after this initial episode, Dr. Grollman had the opportunity to try emetine again on a 48-year-old woman who had a stony hard inoperable pelvic mass with abscess and fistula formation, diagnosed by biopsy as nonspecific necrotizing granulomatous tissue. Five weeks after starting the drug, the mass had disappeared and many years later when reexamined the woman was free of recurrence. Patients with other abdominal masses, tubo-ovarian masses, fibroperitonitis, chronic osteomyelitis, unresponsive chronic mastoiditis, regional enteritis, ileocolitis, malacoplakia of ureters, and Weber-Christian nonsuppurative panniculitis were subsequently treated carefully with emetine, with impressive and salutary results.

It is clinical conviction and tenacity of pursuit that causes the clinical investigator to assume a vital role in medical progress. Dr. Aaron Grollman may proudly take his place as an honored member of this special category of contributing physicians.

E. Gordon Margolin, M.D.
Cincinnati, Ohio
Guest Editor

Medical Historians to Meet in Granville

The annual meeting of the Ohio Academy of Medical History will be held on Saturday, April 18, beginning at 10:00 a.m., at the Granville Inn, Granville 43023. Persons wishing to stay overnight should make reservations directly with the inn.

Morning and afternoon sessions will feature presentations of papers principally by members of the group. Presentation time should be not more than 30 minutes. Projection equipment needs should be made in advance.

Persons who would like to present papers, or who wish additional information, are invited to contact Genevieve Miller, Ph.D., Secretary-Treasurer, Howard Dittrick Museum of Historical Medicine, 11000 Euclid Avenue, Cleveland 44106. Members and other persons on the mailing list may expect copies of the program and luncheon reservation forms some time in March.


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Clinical & Scientific Features







Abstracts from Regional Meeting of American College of Physicians

EDITOR'S NOTE: Again this year *The Journal* is pleased and proud to publish abstracts of the papers read at the Combined Regional Meeting of the American College of Physicians for Ohio, West Virginia, and Western Pennsylvania, November 21-22, 1969, at the Greenbrier Hotel, White Sulphur Springs, West Virginia. The abstracts present in concise form a wealth of information reflecting the nature of current medical research in this part of the country. We are indebted to Dr. Stanley R. Shane and his Program Committee for the selection of the papers and to them and Drs. Edmund B. Flink, Charles H. Rammelkamp, Jr., and William M. Cooper, Governors of the College for West Virginia, Ohio, and Western Pennsylvania, respectively, for permission to publish the abstracts.

* * *

A Recognition of Digitalis Intoxication in the Presence of Atrial Fibrillation

H. Michael Dean, M.D., and Edward K. Chung, M.D., West Virginia University, Morgantown, West Virginia

From the Division of Cardiology, Department of Medicine, West Virginia University School of Medicine, Morgantown, West Virginia

Cardiac arrhythmias alone, instead of the more classic symptoms such as gastrointestinal, are often the first and only manifestation of digitalis intoxication, especially with the purified glycosides. Faced with atrial fibrillation (AF), the presence of digitalis toxicity may be particularly difficult to recognize. The purpose of this paper is to improve diagnostic acumen of arrhythmias caused by digitalis overdosage in patients with preexisting AF by reporting our experience with 87 such patients.

The majority of patients (79) had coronary and/or hypertensive heart disease; five had rheumatic heart disease; two cardiomyopathy; and one thyrotoxicosis. Age ranged from 31 to 89 years.

A-V nodal escape rhythm (A-V NER) or nonparoxysmal A-V nodal tachycardia (A-V NT) was present in 95 percent (83/87). Three patients had frequent multifocal ventricular premature beats. One developed atrial flutter with high degree A-V block. The clue to the diagnosis is the onset of a slow or rapid regular rhythm in someone with long standing AF thought already adequately digitalized. A careful analysis of the electrocardiogram is essential; the presence of A-V NER or nonparoxysmal A-V NT may mimic uncomplicated AF clinically and even electrocardiographically.

A-V nodal arrhythmias in the presence of AF are almost pathognominic of digitalis intoxication; they must be looked for carefully since they could

easily be misinterpreted as uncomplicated AF.

* * *

Clinical and Immunological Observations Following Cardiac Transplantation

Lawrence D. Ellis, M.D., F.A.C.P.; Raymond Mark, M.D.; Henry T. Bahnson, M.D.; and Samuel B. Salvin, Ph.D.

From the Departments of Medicine (Dr. Ellis), Pathology (Dr. Mark), Microbiology (Dr. Salvin), and Surgery (Dr. Bahnson) of Presbyterian-University Hospital and the University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

Clinical and immunological observations were recorded during the first year following successful cardiac transplantation. Immunosuppressive therapy consisted of prednisone, azathioprine, and antilymphocytic globulin. The latter was discontinued after 10½ months because of a rising titer of antibody against the horse protein. Clinical complications included five episodes of probable rejection characterized by symptoms of fatigue and dyspnea and electrocardiogram changes of decreased QRS voltage. There was no evidence of cardiac decompensation. Enzyme elevations and thrombocytopenia occurred with the most recent episode. All of the episodes were reversed within 24 to 48 hours by intravenous hydrocortisone and increased doses of azathioprine. The possibility that the last three episodes were serum sickness reactions to ALG is discussed. Severe osteoporosis with vertebral compression fractures and myopathy have been partially disabling to the patient. Recently, diabetes mellitus has occurred. In addition, there have been three herpes simplex oral ulcers and one episode of herpes zoster infection. Cellular immunity appears to have been greatly altered at all steps by the immunosuppressive regimen. Primary humoral antibody response was suppressed but not abolished as evidenced by a progressively rising titer of anti-horse globulin after six months of ALG therapy. Secondary humoral response was not abolished. The reasons for prolonged survival of this patient following cardiac transplantation are not clear. However, studies to assay the immunological adequacy of this patient have been presented in detail. Such observations are necessary for evaluation of the efficacy of immunosuppressive regimens in the prevention of allograft rejection.

* * *

Regional Perfusion and Ventilation of the Lungs

Anthony Seaton, M.D., West Virginia University, Morgantown, West Virginia

Forty-two patients with mitral valve disease were studied. In all patients cardiac catheterization was performed and the regional distribution of perfusion was estimated using radioactive ^{133}Xenon and a scanning technique. In addition, the regional distribution of a single inhalation of ^{133}Xenon gas and regional rates of washout of injected ^{133}Xenon were estimated.

It was found that redistribution of blood from lower to upper lung zones was significantly related to pulmonary arterial and left atrial pressures ($P < 0.001$ and < 0.01 respectively). Even in the presence of severe underperfusion of the lung bases, ventilation was normally distributed in relation to regional lung volume, unless the patient had clinical evidence of pulmonary disease in addition to his mitral valve disease.

The effect and site of active vasoconstriction was investigated in 13 patients by repeating the studies after inhalation of 100 percent oxygen. Increased relative perfusion of the bases was found in most patients. However, some of those with severe pulmonary hypertension showed increased relative perfusion of the apices and the patient with minimal rise in pulmonary arterial pressure showed no real change.

* * *

Cord Blood Plasma Estriol Levels in Infants With the Respiratory Distress Syndrome

John H. Vollman, M.D. (by invitation), John W. Vester, M.D., F.A.C.P., and Donald J. Frank, M.D. (by invitation), Cincinnati, Ohio

Fetal distress and increased pulmonary capillary permeability are two factors of recognized importance in the pathogenesis of neonatal Respiratory Distress Syndrome (RDS). Fetal distress has been correlated with falling maternal urinary and plasma estriol levels by several workers. It has also been shown that experimentally induced increased capillary permeability in both pulmonary and a nonpulmonary tissue can be prevented or diminished by prior administration of estriol. It is thus within the realm of possibility that diminished fetal plasma estriol levels may have a causal relationship to the development of respiratory distress syndrome.

In this study, umbilical cord blood is collected, at birth, from all infants classified as being high risk RDS candidates. The criteria for this classification include prematurity (37 weeks or less); maternal diabetes, vaginal bleeding, poor past obstetrical history, emergency section, etc. Standard clinical criteria were employed to divide the infants studied into one group that developed RDS and another that did not. The total group studied to date comprises 62 infants classified as prime RDS candidates. The mean cord blood

estriol level, measured by the spectrophotofluormetric method of Levitz and Nachtigall was 85.9 micrograms % ± 8.7 (SEM) in the 17 infants who developed RDS. The mean level in the 45 infants in the high risk group that did not develop RDS was 145.9 micrograms % ± 10.2. The difference between the two groups is highly significant ($T=4.48$; $p<0.001$). Though these data are preliminary they do not appear to be dependent upon gestational age, sex, or type of delivery. In conclusion, the data support the concept that the increased pulmonary capillary permeability felt by many to be responsible for respiratory distress syndrome may be causally related to low fetal levels of estriol at birth.

* * *

Drill Needle Lung Biopsy

A. Dahhan, M.D. (by invitation), William R. Biddlestone, M.D. (Associate), H. Scott VanOrdstrand, M.D. F.A.C.P., and D. Hillsman, M.D. (by invitation), The Cleveland Clinic Foundation, Cleveland, Ohio

This method of percutaneous needle lung biopsy was recently developed by Steel in England, who has successfully used the technique for accurate diagnosis, especially in a number of diffuse pulmonary diseases. It basically consists of a trephine attached to a small pneumatic drill driven at a speed of 15,000 revolutions per minute.

The drill method is found to increase the incidence of positive diagnosis in diffuse lung disease, where the lung is still quite compliant. Past methods have been successful in the more "stiff" lungs.

No serious complications have occurred; only the usual reactions attendant to needle lung biopsy have been noted, namely, occasional transient mild hemoptysis and/or transient minimal pneumothorax.

* * *

The Coma Profile

Charles E. Willis, M.D. and John W. King, M.D., F.A.C.P., The Cleveland Clinic Foundation, Cleveland, Ohio

In order to reduce the time for diagnosis of patients in coma, a series of laboratory tests has been devised. All of these are performed on a "stat" basis. This "coma profile" is designed to expedite the unexplained reason for the patient's comatose state with a minimum of the physician's time.

The common causes of coma are discussed and the simplest test for elimination or detection of each cause is briefly mentioned. Samples of whole blood, spinal fluid, urine, and gastric contents are sent directly to the laboratory where one technician is put in charge of proper sample distribution.

Blood is then assayed for blood urea nitrogen (BUN) or creatinine, glucose, acetone, alcohol (methyl and ethyl), lactic acid, electrolytes, pH, pCO^2, pO^2, total CO^2, and aspirin and it is cultured. Spinal fluid is analyzed for proteins, glucose, and cells and it is cultured. Urinary proteins, glucose, and acetone bodies are determined along with routine analysis.

Both blood and gastric contents are analyzed for a series of drugs commonly used in suicidal attempts. These are performed by rapid gas chromatography and include the most common barbiturates, meprobromates, Doriden, phenothiazine, and others.

All tests are returned to the physician in charge within one to two hours. Positive tests are called in immediately.

It is hoped that this emergent or stat handling will enable the physician to spend his full time on ventilation, fluids, and other vital problems and still give him an adequate battery of tests to make an early and accurate evaluation of the reason for coma.

* * *

Azathioprine in the Treatment of Chronic Active Hepatitis

Eugene I. Winkelman, M.D., F.A.C.P., Edgar Achkar, M.D., and Charles H. Brown, M.D., F.A.C.P., The Cleveland Clinic Foundation, Cleveland, Ohio

Chronic active hepatitis, defined as continuing or recurrent liver disease of at least six months duration, is characterized by transaminase elevation, hypergammaglobulinemia, serological abnormalities, hepatocellular necrosis, and an associated infiltrate of plasma cells and lymphocytes. Despite treatment with corticosteroids, remissions are rare and prognosis is poor.

Five patients with active chronic hepatitis, who had had exacerbation when corticosteroids were either decreased or stopped, were treated with a combination of Azathioprine and low dose corticosteroids. Liver biopsies were done before this treatment in four or five patients. Within four weeks of initiating therapy, there was clinical and biochemical improvement with all studies becoming normal over a period of two to four months. Three of four repeat liver biopsies showed disappearance of the pathologic changes, and the remaining biopsy showed a regression towards normal. All patients returned to normal activity.

Therapy was stopped after one year in two

patients, and shortly thereafter, both liver function tests and liver biopsy became abnormal. Azathioprine was restarted, and liver function tests returned to normal. Corticosteroids were discontinued in four of the five patients who have continued to do well on small doses of Azathioprine alone—(2 to 3½ years). Side effects were minimal and responded to reduction of Azathioprine.

Ten patients with established cirrhosis did not improve on a comparable program.

* * *

Azathioprine Therapy for Inflammatory Bowel Disease
A Preliminary Report

Charles H. Brown, M.D., F.A.C.P., and Edgar Achkar, M.D.

From the Department of Gastroenterology, The Cleveland Clinic Foundation, Cleveland, Ohio

Twenty patients with Crohn's disease and ten patients with chronic ulcerative colitis were given azathioprine in addition to other treatment. These patients had some indication for surgical treatment, and some had complications believed by many to respond only to surgical treatment. Three were excluded from the series because they took medication for less than one week.

The drug was well tolerated in the dosage used (100 mg. daily). Three patients developed temporary leukopenia but were able to continue medication. One patient developed fever, myalgias, and arthralgias, necessitating discontinuation of the medication.

Results to date are impressive. Of the 27 patients on continued treatment, only one has required surgery and must be regarded as a failure of drug therapy. Indolent rectal fistulas and stomal ulcerations healed in two patients. Patients with other complications (toxic megacolon, vasculitis, erythema nodosum, rheumatoid arthritis, lupoid hepatitis — one each) responded to treatment. For 18 patients, azathioprine was the only change in therapy; 14 of these did well with the addition of azathioprine to their treatment program. Flare-ups of the disease occurred in two patients when dosage of azathioprine was decreased or discontinued; flare-ups subsided with resumption of full dosage of azathioprine.

Preliminary results of addition of azathioprine to other treatment are encouraging, suggesting that therapy with azathioprine alone, and blind and random control studies in conjunction with other therapy, would be highly worthwhile. Although the use of azathioprine in treatment of inflammatory bowel disease must still be considered experimental, preliminary results are sufficiently encouraging to proceed with further studies.

* * *

Patients' Cooperation with Various Aspects of a Prophylactic Program for Peptic Ulcer

Harold P. Roth, M.D., F.A.C.P., Herbert S. Caron, Ph.D. (by invitation), and Bartholomew P. Hsi, Ph.D. (by invitation)

From the Department of Medicine, Cleveland Veterans Administration Hospital, and Case Western Reserve University, Cleveland, Ohio

Objective measures of intake of antacid and anticholinergic were obtained on 160 patients who were being followed in a two-year prophylactic program for peptic ulcer. This paper also reports the regularity of clinic attendance and the interrelationships among levels of intake of different medications and attendance at clinic.

Of the 160 patients, 64 either dropped out or were lost to follow-up. For the 96 patients who completed the program, antacid intake was only half the amount prescribed (53 percent). There were wide variations among patients but the individual patient was relatively consistent in his antacid intake. Further, patients showed no significant decrease in antacid intake over the two years of follow-up.

Intake of atropine (as measured with a urine thin-layer test) correlated significantly with antacid intake ($r=.62$), but showed no correlation with the number of tablets for which the patient requested and received prescriptions. Moreover, review of hospital pharmacy records showed that patients filled only about half of their prescriptions. The number of pills actually obtained showed a low, but significant correlation ($r=.38$) with the urine tests.

Patients required to pay for their medication took more than those who obtained it free.

Patients were scheduled for 10 to 12 clinic visits and kept two-thirds of their appointments, a level of attendance that did not decrease during the study. Patients with poor attendance also showed low antacid intake, but patients who kept 100 percent of their appointments showed no better intake that those who only kept 75 percent of their appointments.

* * *

Steatorrhea in Thyrotoxicosis: Relationship to Hypermotility and Excessive Dietary Fat Intake

James H. Caldwell, M.D. (by invitation), and Norton J. Greenberger, M.D. (Associate)

From the Department of Medicine, The Ohio State University College of Medicine, Columbus, Ohio

Relatively little attention has been directed toward intestinal absorptive function in hyper-

thyroidism. Steatorrhea has been reported in a few patients and it has been suggested that diarrhea and weight loss in this disorder might be due in part to alterations in intestinal absorption. To further evaluate this possibility, we have studied intestinal absorptive function in five patients with untreated hyperthyroidism. The patients were hospitalized on a metabolic ward, and balance studies were carried out for four- to-seven-day intervals. The diagnosis of hyperthyroidism was established by typical clinical findings and characteristic laboratory abnormalities (serum protein-bound iodine, T^3 resin uptake, I^{131} uptake). Tests reflecting intestinal absorption (D-xylose, Vitamin B^{12} absorption, small bowel biopsies, prothrombin time, serum calcium, iron and albumin) were normal in all subjects. However, all patients exhibited rapid intestinal transit time by x-ray with barium reaching the colon in 60 minutes. Quantitative fecal fat excretion was normal in four of five patients. One patient had gross steatorrhea (26 gm. fecal fat per 24 hours) but his dietary fat intake was 320 gm. per 24 hours and coefficient of fat absorption 92 percent (normal $>$ 94 percent). Therefore, gross steatorrhea in this patient was due to an enormous dietary fat intake secondary to hyperphagia. Others have reported that animals with experimental hyperthyroidism have marked intestinal hypermotility. The data obtained in this study and from the literature, indicate that intestinal absorption is usually normal in hyperthyroid patients and that steatorrhea, when present, may be due to (1) intestinal hypermotility and (2) hyperphagia with ingestion of excessive dietary fat.

* * *

L-Dopa in the Treatment of Parkinsonism

John Campbell, M.D. (by invitation), James L. Armitage (by invitation), and Helen Berry, M.D. (by invitation), Good Samaritan Hospital, Cincinnati; University of Cincinnati College of Medicine; and The Children's Hospital Research Foundation, Cincinnati, Ohio

Some ten years ago catecholamine excretion in patients with parkinsonism was noted to be low and the dopamine content of the basal ganglia was found to be decreased. Because of this, the substance dihydroxphenylalanine was given intravenously in patients with rauwolfia or chlorpromazine induced parkinsonism with transitory relief.

Through a series of studies based upon the pathologic findings of decreased pigmentation and decreased dopamine content in these nuclei, others attempted to relieve the symptoms of parkinsonism by oral administration of dihydroxphenylalanine. The D-L form was toxic to the blood forming organs but did give definite relief of the slowness of movement and rigidity as well as the tremor, but to a less extent. Finally the levarotatory substance was used in a smaller dose and resulted in significant and often dramatic relief of symptoms.

We have treated approximately 100 patients in the past 18 months on an average dose of 3 to 4 grams a day of L-Dopa.

Our results are similar to that noted by Cotzias, Yahr, both in New York, and now many others. Two thirds of our patients showed significant to dramatic relief of symptoms, and 10 to 15 percent of the patients cannot tolerate the drug. The side effects are usually minimal and transitory. Chemical studies on excretion of this drug have been performed.

The drug is principally excreted as homovanillic acid and dihydroxyphenylacetic acid. Dopamine excretion occurs after the above metabolic pathways have been saturated.

* * *

"Black Lung" or Coalworkers' Pneumoconiosis

N. LeRoy Lapp, M.D., West Virginia University, Morgantown, West Virginia

Coalworkers' pneumoconiosis (CWP) is a diagnosable condition of the lungs caused by the inhalation of coal dust. It was first described as a distinct entity different from silicosis by Collis and Gilechrist (1928) and confirmed by Gough (1940). The pathologic lesion in this disease is characterized by an accumulation of coal dust around the first division of respiratory bronchioles. These coal maculae are accompanied by slight reticulin fibrosis and dilation of the respiratory bronchiole — so-called focal emphysema. Massive collagenous fibrosis and obliteration of the pulmonary vascular bed leading to cor pulmonale occur in from 1 to 3 percent of active miners.

A history of occupational exposure and the presence of small or large nodular opacities on the chest radiograph are required to recognize CWP during life. Approximately 10 percent of working miners and 18 percent of non-working miners have roentgenographic evidence of CWP. Physiologic impairment in early CWP consists of a widened A-a gradient for oxygen and a reduction in diffusing capacity with little decrease in ventilatory capacity. In more advanced CWP, ventilatory capacity falls, gas exchange is further altered, and pulmonary hypertension occurs.

* * *

Environmental Bioeffects and Internal Medicine

Robert T. P. deTreville, M.D., Sc.D., President, Industrial Hygiene Foundation of America, Inc., Pittsburgh, Pennsylvania

At a meeting on The Future Role of Departments of Preventive Medicine in Occupational Health held at Mont Chateau Lodge on January 10-11, 1969, under sponsorship of the West Virginia University Medical Center's Department of Preventive Medicine, attention was directed toward the need to build into future medical students an awareness that specialized knowledge exists to allow proper evaluation of environmental bioeffects on man and that this knowledge can be made available if he knows enough to ask for help when he encounters problems.

It has been estimated by the American Medical Association that 92 percent of the nation's practicing physicians perform one or another type of service to industry. Increasingly, the communications media are filled with information — some inaccurate — on adverse environmental bioeffects. Laws are being passed which incorporate health standards, such as "threshold limits" of hundreds of chemicals. Doctors advising the nation's 80 million workers will have to make decisions concerning subclinical effects of above threshold exposure to physical and chemical agents. To whom will they turn for consultation if not the specialists in scientific medicine represented in the membership of the American College of Physicians. Internists will use the same sorts of scientific principles and methods in environmentally related problem-solving as they use in handling traditional internal medical and laboratory diagnoses. The subject matter will be entirely different in most cases, however, the acceptance of responsibility for proper handling of the case involves very similar ethical considerations.

Ways will be discussed in which the American College of Physicians' members can prepare themselves to accept responsibility for and deal effectively with environmental problems which involve:

1. Toxicologic information research;
2. Threshold limits concepts and their use in industry;
3. Diagnosis, care, and rehabilitation of an alleged occupational disease case; and
4. Environmental epidemiological opportunities in preventive medical practice, from the standpoint of an internist/consultant.

* * *

Suicide in a Large Industrial Population

Gordon M. Mindrum, M.D., F.A.C.P., Cincinnati, Ohio

Suicide is a frequent cause of death. Nationally, it stands as the tenth leading cause of death. Among college students, it is the second most common cause of death. In an industrial population of 15,000 workers studied over a 17-year period, suicide has been the fifth most common cause of death.

There has been a striking lack of practical information on this matter in the medical literature. A mental health program has been initiated in the industrial plant to try to prevent suicides and to aid in other emotional disorders. In this plant, there is a detailed preemployment and periodic examination program. There is apptitude testing, security investigation, detailed work history while on the job, as well as periodic performance appraisals. In addition, health insurance records are available to the medical section, and in some cases, there is psychological testing.

Twenty-six suicidal victims were studied in depth. Treatment of the potential suicide victim has shown some encouragement. The suicide rate during the first 11-year period was 1.30 per 10,000 employees per year. Over the last six years, since the Mental Health Program has been organized, the rate has been reduced to 0.95 per 10,000 employees per year.

* * *

Development of New Information Systems and a Health Sciences Library at the Ohio State University

John A. Prior, M.D., F.A.C.P., and Richard L. Meiling, M.D. (by invitation), Columbus, Ohio

The College of Medicine recognizes that one of the most critical problems for the health scientist is the management of the exploding information. The College (1) is convinced that its library should be the cultural, intellectual, and informational center; (2) is committed to a phased program for the development of new information services (MEDLARS, C-BAC, on-line access to bibliographic information and (under study) Biologic Abstracts); and (3) firmly believes that the Health Science Library must be responsive to the growing informational needs of the scholar which are generated by the new information systems. Consequently, plans provide for a revolutionary Automatic Bookstack System (storage and retrieval of volumes) with all circulation under computer control. Extensive facilities are provided for self-teaching devices including 30 terminals for computer-assisted instruction.

* * *

Zinc-Calcium Interrelationships in Recurrent Renal Stone Formers

L. R. King, M.D., F.A.C.P., W. P. Mulvaney, M.D., and J. R. Johnson, Ph.D., Department of Medicine, Good Samaritan Hospital, and University of Cincinnati College of Medicine, Cincinnati, Ohio

Increased urinary zinc excretion has been noted in association with hypercalciuria. Renal stone analysis indicates a zinc content as high as 0.5 percent. To investigate solute interrelationships in patients with recurrent renal stone formation (SF), zinc, calcium, sodium, and potassium levels were measured in serum and urine by atomic absorption spectroscopy in 22 patients (SF) and 14 normal controls (NC). Total solute excretion was estimated by a Fiske osmometer and urinary specific conductivity by a radiometer type CDM 2d conductivity meter. Serum levels of calcium, zinc, sodium, and potassium were within the normal range in both groups. No difference was noted in urine calcium excretion (SF 156 ± 19, NC 173 ± 18 mg. per day), or total solute excretion (SF 720 ± 59, NC 779 ± 60 mOsm per day). Zinc excretion was significantly different (SF 0.78 ± 0.016, NC 0.43 ± 0.062 mg. per day, $p<.005$), and sodium excretion was significantly different between the two groups (SF 109 ± 13.7 mEq per day, NC 152 ± 16.3 mEq per day, $p<.025$). There was a significant difference in the Na:Osm, Zn:Osm and the Ca:Na ratios between the two groups, but not the Ca:Osm ratios. A significant correlation was found in both SF and NC between total solute excretion and daily calcium excretion ($p<.025$), and total solute and daily sodium excretion ($p<.001$). A significant correlation between calcium and sodium excretion was found in SF but not in NC. On the other hand, zinc and calcium excretion correlated well in NC, but not in SF. These data document a change in urinary mineral excretion in SF which can be characterized as a significant deviation from normal. These changes are probably a secondary phenomenon rather than a prime factor in stone formation.

* * *

Elevated Thyroxine-Binding Globulin in a Family with Goiter

S. R. Shane, M.D., F.A.C.P., and J. E. Jones, M.D., F.A.C.P., Department of Medicine, West Virginia University Medical Center, Morgantown, West Virginia

Elevated Thyroxine-binding globulin (TBG) activity has been found in association with a high incidence of goiter in a new five-generation kindred. Of the 41 members studied to date, 19 have been found to have elevated TBG activity. Fourteen of the 19 affected members and 30 of the 41 total family members have been examined. Twelve of 14 members with elevated TBG activity had goiters. Goiter was found in two and a single nodule in one unaffected family members (one nonconsanguineous). All were clinically euthyroid. The propositis and her sister (generation III) had had thyroidectomies. Thyroid histology revealed nodular colloid goiter in both. Laboratory studies in affected members revealed high TBG (44-91 μg per 100 ml., normal 10-30 μg per 100 ml.), high PBI and T^4I levels (means 15.7 and 13.2 μg per 100 ml.), low resin T^3 uptakes (mean 17 percent), normal G-6PD and thyroxine-binding pre-albumin activity, normal corticosteroid-binding globulin levels and normal free-T^4 and ^{131}I uptake tests in three. Estrogen administration to two affected females caused a 60 percent further increase in TBG activity. Thyroxine-turnover was prolonged with a $T_{1/2}$ of 10.4 days, but T^4 degradation was normal at 51 μg per day in affected female. Chromosomal karyotypes were normal in two affected females.

The elevated TBG trait was found in 11 of 11 daughters and in none of 8 sons of affected males, clearly indicating X-chromosome linked codominant inheritance. The similarity of the inheritance pattern of elevated TBG activity and goiter in this family suggests close linkage of the genetic changes responsible for these traits.

* * *

Long Term Monitoring During Chlorphenoxyisobutyric Acid Therapy

John W. Vester, M.D., F.A.C.P., Thaddeus S. Danowski, M.D., F.A.C.P., and Joseph H. Sunder, M.D. (by invitation), Good Samaritan Hospital and University of Cincinnati College of Medicine, Cincinnati, Ohio, and University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Twenty-two patients with diabetes mellitus have now been treated with chlorphenoxyisobutyric acid (CPIB) for 36 to 51 months at a dosage level of 2 grams per day in divided doses. Eight of the patients had diabetes diagnosed during childhood and have required diet and insulin therapy. In the remaining 14, the diabetes was discovered during adult life and has been managed with diet, with or without tolbutamide. In most, but not all instances pre-therapy laboratory observations were made for three to six months, with or without placebo administration. During treatment, samples of blood and urine were collected for a battery of tests at intervals of three to six months.

The following measurements did not change during the period of observation: body weight,

blood pressure, pulse, blood urea nitrogen (BUN), Co^2, Cl, Na, K, inorganic phosphorous uric acid, creatine and creatinine, total serum bilirubin, cephalin flocculation, thymol turbidity, 24-hour protein excretion, creatinine clearance, 17-ketosteroid excretion, Porter-Silber chromogen excretion, 11-deoxycortisol metabolite excretion, urinary pressor activity, hematocrit, hemoglobin sedimentation rate, white blood cell count, platelet count, prothrombin, bleeding, and coagulation time.

Nonesterified fatty acid levels decreased in the juvenile onset diabetic group, but not in the adult onset group. Serum total cholesterol and triglyceride maintained the 10 to 40 percent drop previously reported *(Clin. Pharmacol. Ther. VII,* 631, 1966). There was an increase of serum protein and albumin levels with a parallel decrease in serum globulin levels in the juvenile onset group. Serum lactic dehydragenese, malic dehydrogenase, and aldolase activities decreased through the 24th month of treatment for which measurements are available. Creatine phosphokinase, alkaline and acid phosphatase, SGOT, and SGPT remained unchanged. Fasting blood glucose levels did not change but the decreases in the hyperglycemic response to an oral glucose load observed during the third month of CPIB administration were still evident at the 36th month.

These data, the results of an intensive long term survey, indicate that CPIB is a hypolipidemic agent with a high degree of safety.

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A New, Potent Oral Hypoglycemic Agent of Low Toxicity Diabeta (Glyburide, HB 419)

Joyce Herrold, M.D. (by invitation), Manuel Tzagournis, M.D. (Associate), and Thomas Skillman, M.D. (by invitation), Department of Medicine, The Ohio State University Hospitals, Columbus, Ohio

Twenty adult-onset diabetics were studied to determine the safety and efficacy of Diabeta (Glyburide, HB 419), a new oral anti-diabetic sulfonylurea approximately 100 times as potent as tolbutamide. Laboratory and clinical evaluations of diabetic control were made at regular intervals during 8 weeks of treatment with the oral hypoglycemic agent and during 8 weeks of treatment with a lactose placebo. Laboratory tests for hematologic, renal, and hepatic toxicity, as well as individual subjective measurements, were also determined during the 16 week study. The severity of diabetes was evident by the fact that the mean fasting serum glucose level of the 20 untreated patients was 228 mg. per 100 ml. Seventeen of the 20 subjects showed improvement in diabetic control while taking the drug as compared to the placebo, one showed no change, and two were therapeutic failures. In spite of using an average dose of only 7 mg. per day (2.5 to 20 mg. range), the mean decrease in fasting glucose was 76 mg. per 100 ml. ($p<.05$). A statistical evaluation of 33 subjective and objective measurements using the Cochran Q Test, McNemar Test, analyses of variance, and Newman-Keuls Test was done Other than the expected hypoglycemic effect of the drug, the only statistically significant finding was an increase in serum thymol turbidity from a baseline mean of 16 to a treatment mean of 22 mg. per 100 ml. ($p<0.05$). These results indicate that, during a short treatment period and in relatively low doses, Glyburide is an effective oral hypoglycemic agent with very few side affects.

* * *

Fatal Starvation-Induced Hypoglycemia

Paul C. Davidson, M.D. (Associate), and Lowell E. Johnson, M.D., West Virginia University, Morgantown, West Virginia

Organic hypoglycemia arises from an inappropriate effect of insulin or insulin-like substances diverting glucose to tissue other than brain or from a failure to supply adequate amounts of glucose from exogenous or endogenous sources. Fatal starvation is infrequent under conditions permitting detailed medical observation. There is some evidence that, excluding deaths from intercurrent infection, hypoglycemia is an important terminal factor. Studies in normal and obese persons indicate that adaptive processes, which maximally spare glucose, develop during prolonged fasting.

A fatal case of starvation secondary to unrecognized intermittent recurrent bowel obstruction was recently studied ante mortem and at autopsy. This 56 year old man had sustained a splenic rupture 15 years ago with subsequent peritoneal splenosis and adhesions resulting in partial bowel obstruction with vomiting and anorexia. He became progressively more cachectic with episodes of lethargy and confusion during the summer of 1969. These were documented as being recurring hypoglycemia and were controlled only by constant intravenous glucose. Upon admission to the West Virginia University Hospital, examination revealed a pigmented, emaciated man with four mm. thick skinfolds generally. There was no

glossitis, no dermatitis, no peripheral neuropathy or peripheral edema. The heart and liver were small. Laboratory studies confirmed the presence of fasting hypoglycemia. The liver biopsy was normal. There were normal growth hormone levels by immunoassay. Steroid levels were normal and increased in response to ACTH. Intravenous tolbutamide did not result in a significant increase in immunoreactive insulin. Intravenous glucagon increased plasma glucose from 78 to 91 mg. per 100 ml. Despite the patient's state there was no ketonuria. The carbon dioxide content was normal. The free fatty acid level was 0.108 mEq/liter and the serum albumin was 2.0 mg. per 100 cc.

An upper gastrointestinal x-ray study revealed dilatation of the duodenum and very proximal portion of the jejunum without further progression of the barium over a 24-hour period.

Therapy was directed toward repleting the glycogen and amino acid stores while maintaining the plasma glucose level. There was an average daily infusion of 2440 ml. of fluid with 469 gm. of glucose, 85 mEq. of potassium, 198 mEq. of sodium, and high doses of B vitamin for three days. On the fourth day he developed pulmonary edema. This was treated vigorously but the patient died 17 hours later.

An autopsy revealed splenosis and adhesions obstructing the jejunum. No adipose tissue was found. The lungs were congested.

This case represents hypoglycemia secondary to depletion of glucose sources — glycogen, adipose tissue, and mobilizable amino acids. This represents an infrequently recognized case of organic hypoglycemia.

* * *

Cephalexin, A New Oral Cephalosporin: Clinical Evaluation in Fifty-Four Patients

Robert J. Fass, M.D. (by invitation), Robert L. Perkins, M.D., F.A.C.P., and Samuel Saslaw, M.D., Ph.D., F.A.C.P., The Ohio State University, Columbus, Ohio

Previous studies in this laboratory with cephalexin, a new orally-absorbed cephalosporin, indicated high activity *in vitro* against gram-positive cocci and selected gram-negative bacilli. Oral administration in men and monkeys resulted in significant serum concentrations and antibacterial activity, and experimental staphylococcal and streptococcal bacteremic infections in monkeys responded impressively.

In the present study, the clinical efficacy of cephalexin was evaluated in 54 patients using doses of 1 to 6 grams daily. The majority of infections treated required hospitalization or developed during hospitalization.

Clinical cures were obtained in 23 of 24 acute bacterial respiratory infections including 10 patients with pneumococcal pneumonia, one with staphylococcal pneumonia, 3 with purulent bronchitis, 4 with gram-negative bacillary pneumonia, and 5 of 6 with beta-hemolytic streptococcal pharyngitis. Primary atypical pneumonia in one patient did not respond. Soft tissue infections caused by penicillin resistant and sensitive staphylococci and/or beta-hemolytic streptococci (17 patients) responded dramatically. Four patients with complicated gram-negative and mixed soft tissue infections showed impressive improvement. Therapy of chronic urinary infections frequently resulted in superinfection or relapse. Four episodes of bacteremia without shock caused by *Escherichia coli*, Klebsiella, *Proteus mirabilis*, and a staphylococcus, respectively, were cured with cephalexin alone.

No significant toxicity was observed despite use of as much as 136 grams of cephalexin in a single course of therapy. One patient developed transient Coombs' positivity without hemolysis. Seventeen patients with a history of penicillin allergy received cephalexin without resultant adverse reaction. Thus, the clinical efficacy of oral cephalexin was demonstrated in the treatment of infections with penicillin sensitive and resistant staphylococci, pneumococci, streptococci, and certain gram-negative bacilli.

* * *

Surface Morphology of the Early Hemostatic Reaction

R. H. Shoop; Stanley P. Balcerzak, M.D., F.A.C.P.; N. R. Larrimer, M.D.; and R. E. Lee, M.D., The Ohio State University Hospitals, Columbus, Ohio, and Presbyterian-University Hospital, Pittsburgh, Pennsylvania

Interaction of platelet surface with collagen and with other platelets is vital to initiation of hemostasis. The surface of the early hemostatic reaction was studied by scanning electron microscopy of white and red mural thrombi produced by traumatic injury of iliac arteries of anesthetized rats and correlated with transmission electron microscopy (TEM) of internal structure of similar thrombi. One minute after vessel injury many platelets were seen covering the endothelial break in white thrombi. Platelets were flat or swollen and

most possessed dendritic processes which often blended with collagen strands. Platelets were layered on each other and many appeared to lose cellular identity. No fibrin was evident and pretreatment with heparin did not change appearance of the thrombus. A single layer of platelets also adhered to adjacent normal appearing endothelium. TEM showed platelets apparently adhering to ruptured endothelium and subendothelial collagen at the site of injury. Some platelets were degranulated. Five minutes after injury the surface of the white thrombus was more homogeneous and further raised from the endothelial surface. A small amount of fibrin was present at the periphery of the break. Reduction of blood flow resulted in a red thrombus with a surface that had a few platelets and many red blood cells (RBC) held together by fibrin strands. These studies indicate that early thrombosis in high flow vessels begins by adherence of platelets to ruptured endothelium and subendothelial collagen followed by adherence of other platelets to initial platelets and morphologically normal endothelial surfaces. Fibrin formation and RBC appear unimportant at this stage of white thrombus formation, but are integral to the red thrombus.

* * *

Surface Morphology of Human Leukocytes

T. Michaelis; Stanley P. Balcerzak, M.D., F.A.C.P.; N. R. Larrimer, M.D.; and E. N. Metz, M.D.; The Ohio State University Hospitals, Columbus, Ohio

This study describes surface morphology of normal human leukocytes as they circulate, after surface contact and during phagocytosis. Circulating leukocytes were fixed by dropping blood directly into buffered 1 percent glutaraldehyde (pH 7.4, 37°C). Effect of surface contact was studied by exposing leukocyte suspensions (after Ficoll-Hypaque or dextran sedimentation and buffer dilution) to either glass, aluminum, or gold-coated surfaces for 30 minutes at 37°C before fixing with glutaraldehyde. A similar preparation was used to study anatomy of phagocytosis except that cells were incubated an additional 30 minutes with latex particles before fixation. All cells were examined by the scanning electron microscope (SEM) and many single cells were examined by both light and electron microscopy. Cells studied by both techniques were Wright-stained before gold-coating for the SEM. Circulating leukocytes were spherical, had wrinkled exteriors, and were about the same diameter as red cells. Leukocyte types could not be consistently distinguished by external morphology. With surface contact all cells greatly increased their diameter. Most neutophils were very thin with a smooth surface except for raised areas corresponding to nuclear lobes as seen on light microscopy. Monocytes differed in that their surface was rougher and no nuclear hump was discerned. Eosinophiles and basophiles were less flattened and their large granules were seen in relief. A variety of pseudopods extended from each cell type. One form appeared as a billowing projection often involved in phagocytosis. Another appeared as a veil, while a third was seen as fine filaments which often branched. These latter two forms were rarely found participating in phagocytosis. These studies indicate that each type of normal circulating leukocyte has similar external structure, but that surface contact induces marked changes which permit differentiation of cell type by topography.

* * *

An Acceptable Alternative to Chronic Hemodialysis and Renal Transplantation

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The treatment of end stage renal disease with chronic hemodialysis is severely restricted both by the availability of beds and of money. Similarly, renal transplantation is limited by the number of donor kidneys. Individuals requiring therapy, however, continue to increase. Therefore, a reappraisal of peritoneal lavage as a form of long term treatment for chronic renal failure was undertaken at the Mt. Sinai Hospital of Cleveland. Peritoneal lavage is relatively inexpensive, easy to institute, known to be medically effective, and, therefore, is potentially available for universal use.

Six patients with creatinine clearances less than 5 cc per minute were selected for study. All were maintained utilizing the multiple puncture technique of peritoneal lavage for periods of 19 to 31 months. The treatment schedule was based on symptomatic rather than chemical control. This regimen resulted in an average treatment interval of 3.3 weeks (range 2.4 to 3.6). All six patients were ambulatory, feeling well between treatments,

and in a good nutritional state. Although complications, including neuropathy, renal osteodystrophy, and congestive heart failure with hypertension occurred as expected, none were progressive nor did they present any particular management problem. There were only five episodes of mild peritonitis in 220 treatments. Five of the six patients are still on the program. We suggest that this form of therapy can be employed at infrequent intervals for long periods of time at a minimal cost to maintain patients with chronic renal failure.

* * *

Treatment of Lupus Nephritis with Low Dose Steroids and Anti-Metabolites

Phillip M. Hall, M.D., Donald G. Vidt, M.D., F.A.C.P., Lawrence J. McCormack, M.D., and John R. Haserick, M.D., F.A.C.P., Cleveland Clinic Foundation, and Case Western Reserve University, Cleveland, Ohio

Forty-two patients (32 females, average age 19.2 years; 10 males, average age 29.1 years) have been followed for 4 to 168 months (average 38 months) since the onset of lupus nephritis. All patients had abnormal tests of renal function and all had percutaneous renal biopsies which were categorized as to quality and quantity of change. Thirty-nine patients received a therapeutic regimen consisting of low dose steroids (prednisone <40 mg. per day) and anti-metabolites (nitrogen mustard and/or azathioprine). At the time of biopsy all patients had proteinuria, 23 had a blood urea nitrogen (BUN) greater than 20 mg. per 100 ml., 17 had nephrotic syndrome, and 24 had moderate to severe proliferative or membranoproliferative glomerulonephritis. Fourteen patients died an average of 23 months after the onset of lupus nephritis, seven of renal failure, and all had severe membranoproliferative glomerulonephritis when biopsied.

Twenty-seven patients are alive an average of 56.4 months after the onset of lupus nephritis. Of these survivors, nine had a BUN greater than 20 mg. per 100 ml., ten had nephrotic syndrome, and 13 moderate to severe proliferative or membranoproliferative glomerulonephritis when biopsied. Only 2 of 27 have deteriorating renal function. In all but one of the surviving nephrotic patients, proteinuria has decreased to less than 2.5 gm. per 24 hours. It would appear that a therapeutic regimen of low dose steroids and anti-metabolites can provide prolonged survival with stable renal function in patients with lupus nephritis.

* * *

Fab Disease—A New Disorder of Serum Gamma Globulins

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A previously asymptomatic 51 year old white woman presented with a three week history of radicular pain. Evaluation revealed a 30 percent marrow plasmacytosis, osteolytic skeletal lesions, and a 5.6 grams per 24 hour proteinuria. Serum and urine electrophoresis revealed no typical myeloma spike, moderately elevated serum α^2 globulins, low serum gamma globulins, and a corresponding α^2 mobility band in the urine.

Immunodiffusion indicated that a large portion of the serum and urinary α^2 proteins were normal constituents. Immunoelectrophoretic studies revealed the presence of α^2 Kappa light chains in serum and urine.

No abnormalities were detected in serum run against heavy chain specific anti IgA, IgM, IgG, IgD, and Fc antiserum. An anti-Fab antiserum failed to cross react with homologous and heterologous light chains. It formed a double bumped arc of partial identity with serum over the α^2 to gamma region.

The failure of heavy chain specific antiserum to react with the serum γ^2 region suggests the absence of intact heavy chains. The positive reactions of light chain antiserum establishes the presence of light chains in this region. The positive reaction of Fab antiserum establishes the presence of a heavy chain fragment. The reaction of partial identity between the serum α^2 Fab and gamma-Fab arcs indicates that the proteins in these regions are quite similar, but not identical.

We conclude that these findings provide sound presumptive evidence for the presence of a Fab fragment in the serum and homologous light chains in the urine of a patient with myeloma.

* * *

Renal Disorders in Plasmacytic Disease

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A retrospective study of the incidence and type of renal disease was made in 86 patients with myelomatosis or amyloidosis. Patients with clinical evidence of myeloma were classified as such regardless of the presence or absence of amyloid. Forty-five (52 percent) had a significant renal abnormality (blood urea nitrogen (BUN) above 30 mg. per 100 ml. and/or proteinuria of 0.5 gm. per 24 hours or greater). Uremia was the presenting manifestation in six patients and nephrotic syndrome was in six others.

Proteinuria was generally marked (>2 gm. per 24 hours) in patients with amyloid involving the glomeruli and mild to moderate in myeloma. Bence Jones proteinuria was detected in a total of 37 patients (43 percent). Hypercalcemia (serum calcium >11.5 mg. per 100 ml.) was present in 17 (21 percent) and was associated with azotemia in ten (12 percent).

The median survival in 62 patients with multiple myeloma was greater than 13 months. Nineteen patients with proteinuria alone had a mean survival of 19 months, whereas, in 19 patients with both proteinuria and azotemia it was only three months. The median survival in 14 patients with amyloidosis without multiple myeloma was about five months regardless of presence or absence of initial azotemia (BUN>30 mg. per 100 ml.). Hypercalcemia was readily reversible with treatment and did not appear to affect the mean survival. Histologic examination of the kidneys was available in 27 patients. Seven had findings of "myeloma" kidney. Thirteen patients had amyloid deposition in the glomeruli (two of which had classic myeloma clinically). Two patients had myeloma and azotemia with no apparent etiology and normal renal histology. Renal failure associated with myeloma is potentially reversible and should receive vigorous treatment. One of our patients with chronic renal failure was stabilized without dialysis and is still alive one year later. No effective treatment is available for renal disease due to amyloidosis.

* * *

Androgen Therapy in Patients with Marrow Failure

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(Published here by title only in keeping with request of the authors.)

* * *

GAPS IN DOCTOR-PATIENT COMMUNICATION. — Study of 800 outpatient visits to Childrens Hospital of Los Angeles to explore the effect of the verbal interaction between doctor and patient on patient satisfaction and follow-through on medical advice showed 24 percent of patients to be grossly dissatisfied, 38 percent moderately compliant, and 11 percent noncompliant. The extent to which patients' expectations from the medical visit were left unmet, lack of warmth in the doctor-patient relation, and failure to receive an explanation of diagnosis and cause of the child's illness were key factors in noncompliance. Complexity of the medical regimen and other practical obstacles also interfered with compliance. There was a significant relation between patient satisfaction and compliance. Also, illnesses that the mothers regarded as very serious were associated with increased compliance. There was no significant relation between the demographic variables tested and satisfaction or compliance. — Vida Francis, P.H.N., M.S., Barbara M. Korch, M.D., and Marie J. Morris, R.N., B.S., Los Angeles: *The New England Journal of Medicine,* 280:535-540, March 8, 1969.

Emetine: New Uses for an Old Drug

ARTHUR P. GROLLMAN, M.D.

EMETINE is the active principal of ipecac, an extract prepared from the root of *Cephaëlis ipecacuanha,* a plant which has been in therapeutic use for over three centuries. One of the earliest books published in the western hemisphere[1] described its use by the Brazilian Indians in treating the local form of dysentery. In all likelihood, this disease was amebic in nature.

Following its introduction by the conquistadores into Europe,[2] ipecac was used as a secret remedy for dysentery by Dr. Adrien Helvetius of Paris. Helvetius sold the secret to Louis XIV who, in turn, made the preparation available to the public. Pelletier, who, with Caventou, first isolated morphine, obtained a crystalline alkaloid from ipecac in 1817, which he designated as "emetine," but later this was shown to consist, in fact, of three related compounds, emetine, cephaëline, and psychotrine.

The principal use of emetine has always been in the treatment of amebiasis,[3] and it remains the drug of choice for amebic hepatitis. Melchior first described the use of emetine in severe bacterial infections,[4] and others reported its effectiveness in certain viral diseases.[5] In 1965 and 1966, A. I. Grollman reported clinical studies in which emetine had been used successfully for the treatment of nonspecific granulomas.[6,7] These astute observations stimulated the presently reported investigations on the mode of action of the drug.

Mode of Action

Suspension cultures of fibroblasts represent an experimental model in which the inhibitory effects of drugs on the proliferation of granulomatous tissue can be studied. At the suggestion of A. I. Grollman, the effects of emetine on these cells were examined. Since many cytotoxic agents inhibit the biosynthesis of ribonucleic acid (RNA), deoxyribonucleic acid (DNA), or protein,[8] the effect of the drug on the synthesis of these substances was measured (Fig. 1). At very low concentrations, emetine inhibited the incorporation of amino acids into protein and of thymidine into DNA.[9,10] It was suspected that the observed effect on DNA synthesis was secondary to a primary effect on protein synthesis, since all inhibitors of protein synthesis also inhibit the synthesis of DNA. This interpretation was confirmed by studies using rabbit reticulocytes. In these cells, which synthesize hemoglobin but not DNA, emetine had the same inhibitory effects on protein synthesis that it had in fibroblasts.[9]

It was also found that emetine inhibits protein synthesis in extracts prepared from other cells, including rat liver, yeast, and plants but not bacteria.[9] The effect on protein synthesis was structurally specific, and only chemically related alkaloids, such as cephaëline and dehydroemetine, had similar effects.[9] Recent studies have established that emetine acts on an enzyme known as the "translocase" or transferase II, which is involved in the elongation of the peptide chain. In this respect, it bears a general resemblance to the effects of chloramphenicol and other antibiotics that inhibit the analogous enzymatic pathways of protein synthesis in bacteria.[11,16]

In view of the inhibitory effects of emetine

The Author

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See editorial on page 243.

on protein synthesis in animal cells, it is not surprising that the drug is also cytotoxic. It is interesting to note that two of the most notorious cardiotoxins in man are emetine and diphtheria toxin. Diphtheria toxin has also been shown to be a specific inhibitor of protein synthesis[12] and probably affects the same enzymatic process as does emetine.

Structure-Activity Relationships as a Guide to the Design of New Amebicides

The establishment of the mode of action of emetine provides a lead to the rational design of new chemotherapeutic agents.[13, 16] Recognizing its stereospecificity and its topochemical similarities to cycloheximide (Actidione), it was predicted that structurally related compounds would act by the same mechanism.[8] Pursuing this hypothesis, tubulosine, which previously had not been known to be biologically active, was found to be an inhibitor of protein synthesis and to be a potent amebicide.[14] Anisomycin, which was known to be an amebicide but whose mode of action was not established, was shown to be an inhibitor of protein synthesis.[15] The structure-activity relationships between the foregoing alkaloids and antibiotics allowed the formulation of new agents[16] which are currently being tested as potential amebicides. Since almost one billion people are estimated to suffer from amebiasis,[17] there is an urgent need for an inexpensive amebicide, and it is hoped that these studies may lead to the synthesis of equally potent but less toxic amebicides than are now available.

Antiviral and Antitumor Effects of Emetine

Following the demonstration of its capacity to inhibit the replication of certain viruses in tissue culture,[10] it was reported that emetine protects animals against certain experimental viral infections.[18] Unfortunately, the toxicity of the drug when used for an extended period[19] precludes its therapeutic use for this purpose.

Another therapeutic application, suggested by the above-described experimental studies, is the clinical use of emetine as an antitumor agent. Despite its toxicity, emetine has no suppressive effects on the bone marrow, and it may prove useful when used in conjunction with other antitumor agents. Clinical trials of its effectiveness in certain neoplasia are currently in progress.

Design of Emetic Agents

Emetine, in the form of ipecac, is used as an emetic in pediatric practice for treatment of acute spasmodic croup and acute poisonings. However, the emetic action of the drug and its structural

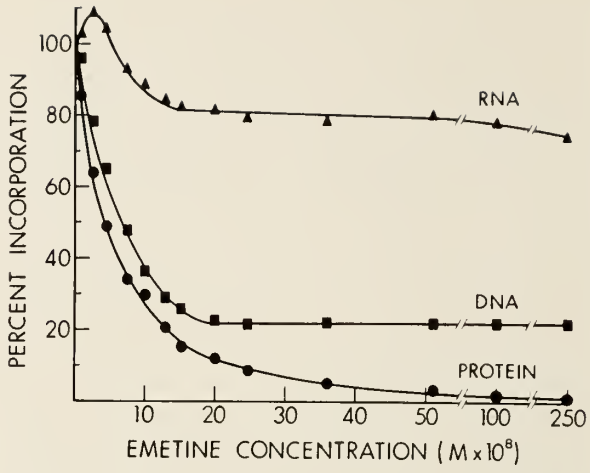


Fig. 1. Effect of emetine on the biosynthesis of protein, DNA, and RNA in suspension culture of HeLa cells. Experimental details are given in reference 10.

analogs do not correlate with their capacity to inhibit protein synthesis. Since the adverse effects, including the cardiotoxic properties, derive from the latter activity, it should be possible to use the biologically inactive analogs of emetine, such as O-methylpsychotrine and isoemetine as potent emetic agents.

Use of Emetine as a Diagnostic Tool

A clinical application, suggested by these studies, is the use of emetine as a diagnostic tool in patients with subdiaphragmatic abscess. The principle for this test derives from the failure of emetine to affect protein synthesis in bacteria, due to the fact that these organisms do not possess the enzymes which are affected by the drug. On the other hand, all protozoa, including *Entamoeba histolytica,* are exquisitely sensitive to the inhibitory effects of emetine. A patient with a suspected subdiaphragmatic abscess should show a clinical response to emetine in 24 hours if the causative agent is amebic in origin. If the infecting organism is bacterial, no response should be elicited, and the diagnostic test would not have interfered with the appropriate cultures being taken for diagnosis.

Conclusion

The scientific application of drug therapy is dependent upon an understanding of the mechanism of action of the drug as well as on the pathologic process which one wishes to modify. The studies on emetine reported in the present paper exemplify this principle of drug therapy. Clinical observations of the antigranulomatous

effects of emetine led to the biochemical study of its mode of action. The alkaloid was found to inhibit protein synthesis in animal cells and amebae in a highly specific manner. Knowing its mode of action and the structural requirements for biological activity, it has proved possible to demonstrate applications of this time-honored drug to conditions other than those for which it has previously been used.

Acknowledgement: The author gratefully acknowledges the suggestions of Dr. A. I. Grollman who provided the initial impetus for these studies. Drs. S. C. Wang and K. P. Bhargava performed the studies on the emetic effects of emetine and its analogs.

Generic and Trade Name of Drug

Cycloheximide — Actidione (Upjohn Co.)

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MEDICAL EDUCATION. — The wide range of the branches of study fundamental to the study of medicine proper, together with the extensive and constantly increasing area of the curriculum of proper medical education, makes it impossible for any ordinary mind to grasp or receive all this vast array of information in the old time period of student life.

This subject of medical education, hackneyed though it be, is bound to be pressed upon the attention of the profession so long as the science of medicine is one that must be acquired by study, research and painstaking toil, and one that is constantly extending, widening and deepening its boundaries with ever increasing advancement. — Transactions of the Ohio State Medical Society, 1888.

The Role of the Gastrocamera in Diagnosis

Henry B. Friedman, M.D., B. H. Sullivan, Jr., M.D., and Charles H. Brown, M.D.

GASTROINTESTINAL ENDOSCOPY has recently benefited dramatically by the availability of new instruments. These have enlarged its scope, improved its efficiency, and facilitated photographic documentation. One instrument, the Japanese Gastrocamera (Olympus Optical Company), provides a series of color photographs of the interior of the stomach and thus precludes the gastroscopist's visual search of that region. The new technic is said to be simpler to use, less time-consuming, better tolerated by patients, and more effective than gastroscopy. The instrument must be considered a descendent of an intragastric camera developed in 1898 by Lange and Meltzing.[1] The improved lighting and the fast, fine-grained, color film now available are the principal reasons why the Japanese instrument has succeeded and the German instrument was abandoned. A practical gastrocamera was described by Uji in 1952 and introduced into the United States by Morrissey at the University of Wisconsin.

The purpose of our study was to determine the role the gastrocamera might usefully play in the diagnosis of gastric disease in patients at a large outpatient clinic.

Methods and Material

The Olympus GT-V Gastrocamera used in these studies is an 11.5 mm by 35 mm metal capsule containing a camera, a film cassette, and a tungsten-filament light bulb at the end of a long vinyl-covered control tube containing an air channel for inflating the stomach, control wires for advancing the film, for flashing the light, and for deflecting the camera. A series of 32 or fewer photographs, each 5 mm by 6 mm, was made in accordance with a predetermined program designed to photograph the entire inner surface of the stomach, including retrograde views of the cardia. Objects in a range from 2 cm to 12 cm from the camera were in focus and properly illuminated.

Two hundred patients were examined. The age ranges of the patients in our group are listed in Table 1. Of the 200 patients, 50 were more than 65 years old and tolerated the procedure well. In almost all cases the radiographic examinations had revealed definite or equivocal evidence of gastric disease. Radiography revealed such abnormalities as an ulcer niche, filling or subtraction defect, constriction defect, pyloric narrowing, "fixed" stomach, hyperrugosity, and findings that were inconclusive but suggestive of benign peptic ulcer, marginal ulcer, or carcinoma of the stomach. A few patients were said to have no abnormal radiographic findings, but they provided the examiner with a strong clinical suspicion of the presence of disease. Gastrocamera photography has been used for follow-up examinations

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in several patients to determine the healing of an ulcer, recurrence of gastric polyps or of cancer, and, in one case of reticulum cell sarcoma, to determine the effect of cobalt 60 teletherapy. One hundred sixty-nine examinations were followed immediately by gastroscopy.

We used the technic of the examination as fully described by Morrissey and associates.[2, 3] The patient was fasting, the premedication was the same as that employed for gastroscopy, usually an intravenous injection of from 50 to 100 mg of meperidine hydrochloride; topical anesthesia to the pharynx was administered in a few instances. Preliminary gastric lavage with an antifoaming agent (1 ml of Dow AntiFoam C dissolved in 30 ml of water) was always performed. In seven instances fluoroscopy was used to aid in positioning and retroflexing the camera. The exposed film was processed in the Olympus Laboratory in New York City, and the finished film strip was examined on the Olympus Projector at the Cleveland Clinic.

Table 1. Age Ranges of Patients Examined with the Gastrocamera

Age Range, Years	Number of Patients
15-24	5
25-34	14
35-44	21
45-54	49
55-64	61
65-74	40
75-84	10

Table 2. Grade of Accuracy of Diagnoses made from Gastrocamera Examinations

Item	Number
Examinations	200
Unsatisfactory photos	12
Satisfactory photos	188
Correct diagnoses	140
Equivocal diagnoses	3
Error in diagnoses	45

Results

The results of our examinations are summarized in Table 2. For all patients the final diagnosis was the clinical or histopathologic diagnosis. The diagnoses by the three chief modalities were compared with the final diagnoses, based on all of the clinical evidence or on histopathologic examination. Interpretation of the gastrocamera photographs was made by a clinician who did not at the time know either the final clinical or the histopathologic diagnosis.

None of the 200 patients experienced adverse effects from the examinations. There were 12 incomplete or unsatisfactory examinations: one was so listed because it was lost in the mail, seven because of insufficient insufflation of the stomach, and two because of excessive gastric secretions. The instrument could not be passed into the stomach in two patients with carcinoma of the cardia of the stomach and obstruction at the esophagogastric junction. Among the other 188 examinations, the correct diagnosis was made for 140 (74 percent). Three equivocal diagnoses were made, and in each of 45 examinations an error in diagnosis was made.

The value of the gastrocamera examinations in relation to various pathologic conditions must be considered also. The greatest error in the examinations with the gastrocamera was with regard to patients having a final diagnosis of gastric ulcer (Table 3). Seventy-eight patients had gastric ulcers, 37 of which were seen by gastrocamera photography, while the correct diagnosis was not made in 41 cases. There were five unsatisfactory filmstrips in this group: the one lost in the mail, two because of inadequate insufflation of air, and two because of mucus that coated the lens. Of the 33 diagnostic errors, in each of five patients a benign ulcer was misinterpreted as malignant by gastrocamera photography. In the other 27 cases, 18 of the photographs were interpreted as normal and 9 as gastritis; in none of these photographs was the ulcer seen. In each of 9 of the above-mentioned 27 patients the ulcer was in the

Table 3. Results of Examination with the Gastrocamera with Regard to Various Diseases

Status	Diagnoses, number				Unsatisfactory photos, number
	Total	Correct	Equivocal	Wrong	
Normal	56	52	0	2	2
Gastric ulcer	78	37	3	33	5
Marginal ulcer	7	5	0	2	0
Gastritis	16	12	0	4	0
Benign tumor	12	12	0	0	0
Malignant tumor	31	22	0	4	5
Total	200	140	3	45	12

prepyloric region, an area not well photographed with the GT-V gastrocamera. The diagnosis of gastric ulcer in three patients was made roentgenographically only; in those patients the ulcer was visualized neither by means of gastrocamera nor by gastroscopy. One ulcer, well demonstrated on roentgenograms to be high in the fundus, was sought by turning the gastrocamera. This maneuver was successfully accomplished and the fundus was well photographed but the ulcer was not seen; an active ulcer was confirmed at laparotomy.

Marginal ulcer is difficult to diagnose roentgenographically and cannot always be seen by gastroscopy or by means of gastrocamera photography. However, good photographs were obtained in five of seven patients in whom a diagnosis of marginal ulcer was made.

In 12 of 16 patients in whom a diagnosis of gastritis was made, diagnostic gastrocamera photographs were obtained. The other four patients were thought to have normal gastrocamera photographs, but through gastroscopy were seen to have gastritis. The excellent demonstration of the upper portion of the stomach by gastrocamera photography initially led us to "overread" the diagnosis of "atrophic gastritis." In almost all of the patients examined, large areas of pale mucosa with prominent mucosal vessels were seen in the upper portion of the stomach. A normally thin membrane, stretched by the gastric inflation necessary for photography, probably explains this effect. This observation is now regularly confirmed by us at gastroscopy, and these changes are considered normal by us as long as they are confined to the upper third of the stomach. A similar observation was made at gastroscopy by Ruffin and Brown[4] in 1940.

Benign tumors of the stomach were discovered in 12 patients (gastric polyps in 10 and leiomyomas in 2); all of the tumors were successfully photographed and none of them was in the prepyloric region.

A diagnosis of malignant gastric neoplasm was made for 31 patients, 26 of the diagnoses were proved at laparotomy at the Cleveland Clinic Hospital. There were 27 carcinomas and four lymphomas. The gastrocamera successfully photographed 22 of these neoplasms. There were unsatisfactory photographs of five; three of the gastrocamera examinations were unsatisfactory due to inadequate insufflation of the stomach. The wall of the stomach infiltrated by neoplasm is not so distensible as is a normal gastric wall, and it is therefore difficult for those patients to retain sufficient air for successful gastrocamera photography. In two other patients in this group, the gastrocamera could not be passed through the esophagogastric junction because of neoplasms; therefore no photographs were made. The gastroscope, likewise, could not be passed into the stomach of those two patients. There were four errors in diagnosis: three photographs were incorrectly interpreted as benign peptic ulcers and one was thought to be hypertrophic gastritis.

Table 4. Comparison of Results from Roentgenographic, Gastroscopic, and Gastrocamera Examinations

Item	Examination by		
	Roentgenography	Gastroscopy	Gastrocamera
Examinations, total no.	186	167*	188†
Accurate postive diagnosis	81 (44)%	130 (79%)	140 (74%)
Equivocal diagnosis	50 (27%)	6 (3%)	3 (2%)
Error in diagnosis	55 (29%)	31 (18%)	45 (24%)

*Unsatisfactory examination in 2 patients; gastroscope could not be passed.

†Unsatisfactory examination in 12 patients (see text).

In several patients, the gastrocamera photographs proved decisive in the accurate diagnosis of the gastric lesions. The following three cases illustrate the value of the gastrocamera in diagnosis.

Report of Three Representative Cases

Case 1. A 63-year-old man was examined at the Cleveland Clinic on June 27, 1966, because of anorexia, belching, and mild epigastric pain intermittently for six months. Roentgenograms of the stomach showed only inadequate filling of the gastric fundus. Gastroscopic examinations revealed only atrophic gastritis; no neoplasm was seen. The gastrocamera successfully photographed a large polypoid ulcerating carcinoma in the upper portion of the stomach. The diagnosis was confirmed at laparotomy.

Case 2. A 67-year-old man was examined at the Cleveland Clinic on April 1, 1966, because of melena, anorexia, and loss of weight in the preceding six weeks. Roentgenograms of the stomach were interpreted as showing a possible carcinoma affecting the body of the stomach. Gastroscopic examination revealed multiple polyposis. The gastrocamera photos demonstrated a carcinoma affecting the posterior wall of the stomach. This diagnosis was confirmed at laparotomy.

Case 3. A 25-year-old woman was examined at the Cleveland Clinic on September 28, 1967, because of anorexia and upper abdominal pain of five months' duration. Roentgenograms of the stomach showed two large ulcers on the greater curvature, which appeared to be benign. Gastroscopic examination showed multiple large nodules in the antrum of the stomach, with ulceration of some of the nodules. This was thought to represent lymphomatous involvement of the stomach. These findings were confirmed by gastrocamera examination. Subsequent biopsy of skin and breast lesions revealed reticulum cell sarcoma.

Comment

Comparison of gastrocamera diagnoses with those from radiography and gastroscopy is made

in Table 4. An accurate positive diagnosis was made for 81 (44 percent) of 186 patients examined by roentgenography, 130 (79 percent) of 167 examined by gastroscopy, and 140 (74 percent) of 188 examined by the gastrocamera. Equivocal reports such as "cannot exclude infiltrating neoplasm," or "possible gastric ulcer," were not considered to be positive diagnoses. Such equivocal results were recorded in 50 of 186 roentgenographic studies, in 6 of 167 gastroscopic examinations, and in 3 of 188 gastrocamera examinations. An error in diagnosis was made in 55 cases by means of roentgen examination, 31 by means of gastroscopic examination, and 45 by means of gastrocamera examination.

Discussion

In our first efforts,[5] the gastrocamera as a diagnostic tool was somewhat less accurate than the gastroscope in the detection of benign gastric ulcers. This failure to detect as many ulcers with the gastrocamera as with the gastroscope has continued into the present series and is at variance with several previously reported series of examinations.[2, 3, 6, 7] In one of their series, Morrissey,



FIG. 1. Benign gastric ulcer on lesser curvature of mid-stomach. The margins are sharply demarcated.

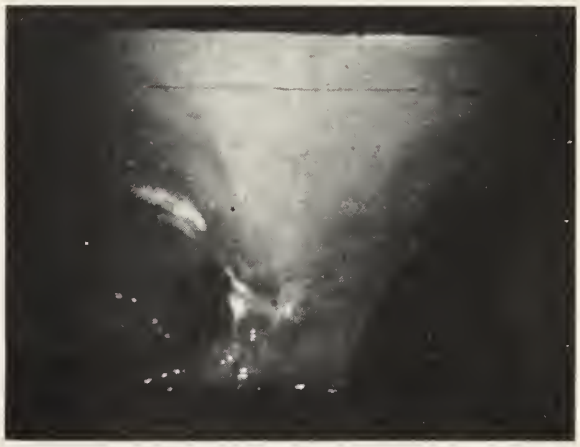


FIG. 2. Adenocarcinoma of lesser curvature of stomach. An irregularly shaped ulceration with poorly defined margins is associated with nodularity of nearby mucous membrane.

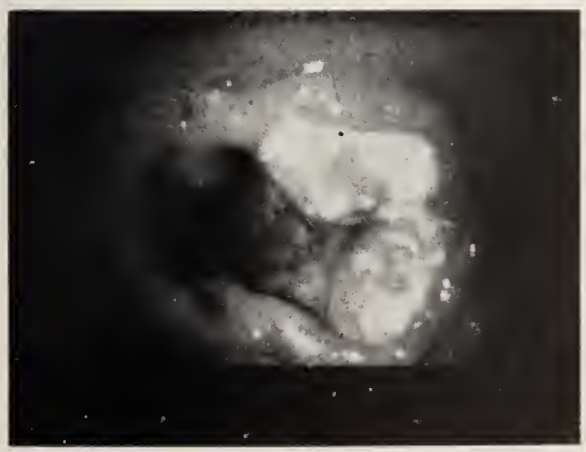


FIG. 3. Large adenocarcinoma of body of stomach, with central ulceration.



FIG. 4. Benign adenomatous polyps, upper portion of stomach.

Hara, and Perna[2] discovered that when the gastroscopist had not seen roentgenograms before performing an examination, he was not able to concentrate on a specific area of the stomach, and more new ulcers were therefore photographed by gastrocamera examination than were seen by gastroscopy.

The gastrocamera best demonstrates lesions in the antrum or on the angulus of the stomach. Photography of the pylorus is difficult because of its inability to distend sufficiently. In addition, the GT-V instrument is not long enough to reach the pylorus in many patients, an inadequacy that has been recently overcome by the development of a newer instrument, the GT-Va, which is longer and more flexible than the GT-V.

The gastroscopist has an advantage in that he may continue his efforts until he sees the ulcer, while the gastrocamera operator formerly could not be sure of his results until the films were processed and returned to him. This disadvantage has been overcome by the development of the GTF and GTF-A instruments (the latter has a controllable tip, the former does not) which combine gastroscopy and photography in one instrument. Inspection of the stomach is continued until the lesion in question is identified and photographed.

The gastrocamera is not intended to replace but rather to complement other current methods for diagnosing intragastric pathologic changes. There are three situations in which the gastrocamera seems to be useful. (1) It can photograph regions that are not seen by means of gastroscopy and are sometimes difficult for the radiologist to examine satisfactorily. The cardia and fornix are examples of such areas, and we believe that it is important to attempt to turn this instrument in as many patients as possible to photograph these areas. (2) The gastrocamera can be used for interval examinations of a specific patient to study progress of a lesion or to determine whether or not a lesion has recurred. It is less traumatic for the patient than to repeat gastroscopic examinations, and all photographs can be compared. In addition, the photographs can be reviewed by persons who were not present at the examination. (3) The gastrocamera photographs constitute a teaching file for the instruction of beginning students of gastroscopy. A good filmstrip, with its excellent color rendition of the gastric mucosa and its sharp definition, taken in precise and orderly fashion, is of great help in orienting the beginning gastroscopist.

The GT-V gastrocamera provides the highest quality photographs of the interior of the stomach available at this time. There are a number of disadvantages to the employment of the instrument, the two most obvious being the delay required for processing the films and the inability of the operator to determine that the portion of the stomach in question has, in fact, been properly photographed, in other words, the lack of a view-finder. This latter objection is overcome by the Olympus GTF-A gastroscope with deflecting tip and with a gastrocamera incorporated near the tip of the instrument. With this arrangement, the stomach can be searched by the gastroscopist until the area of interest is located and photographs are taken. We believe that the entire stomach should be photographed in a systematic fashion with this instrument, even though a complete inspection was made visually. The angle of view of the gastrocamera lens is greater than that of the gastroscopic lens, and the two lenses are separated a little so that the photographs include everything that was seen and a bit more. Occasionally the photographs will show a lesion not identified at gastroscopy.

But the GTF-A fiberoptic gastroscope with deflectable tip and gastrocamera has its drawbacks. It is not always possible to get fully satisfactory views of the immediate prepyloric region and pylorus because of the size of the rigid tip of the instrument. Biopsy facilities are not incorporated, and the light source is the now old-fashioned incandescent bulb. The current model of the Hirschowitz fiberoptic gastroscope (American Cystoscope Company) has a directable tip of small size, external fiberoptic light source, and a rather unsatisfactory device for biopsy. Photographs must be made with an external camera and, while good, are not of the same high quality produced by the intragastric camera. Schuman, Carandang, and Priest[8] have stressed the value of the gastrocamera in the examination of elderly patients. They reported on its value in 110 patients more than 65 years of age and concluded that the procedure was well tolerated and safe. Our experience confirms their conclusions.

Our current opinion is that one must employ the instrument that will allow inspection of the greatest portion of the stomach and give definitive evidence immediately. We believe, therefore, that the gastrocamera, with all of its virtues, cannot replace the modern fiberoptic gastroscope in daily clinical practice.

Summary and Conclusion

Two hundred gastrocamera examinations have been performed at the Cleveland Clinic since December 1965. The results, when compared with roentgenographic and gastroscopic examinations of the same patients, indicate that it is as accurate as either of these procedures in detecting intragastric disease, with the exception of prepyloric lesions. The inaccuracy in the diagnosis of ulcer

was in some measure due to the operators' inexperience, particularly in the early phase of the study.

The gastrocamera photographs, in several instances, made possible a definitive diagnosis for patients with equivocal roentgenographic findings. One patient (case 1) was thought to have a normal stomach according to roentgenograms, and atrophic gastritis at gastroscopy. When the gastrocamera photographs were reviewed, a carcinoma of the fundus of the stomach was seen; this was confirmed at laparotomy. In several other instances, when roentgenographic and gastroscopic studies were in disagreement as to whether a lesion was benign or malignant, gastrocamera examination resolved this dilemma (see case presentations). We therefore believe that the gastrocamera is an excellent diagnostic instrument. Inability to determine at the time of examination whether or not the suspected region of the stomach has been photographed, and the time lost due to film processing seriously limit the usefulness of the gastrocamera GT-V in daily clinical practice. The combination of the gastroscope and the gastrocamera into one instrument (GTF-A) overcomes these objections.

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THE CLASSIFICATION OF ANTIBACTERIAL DRUGS into bactericidal and bacteriostatic groups is of clinical value. Bactericidal drugs are to be preferred when possible as they are more rapidly effective, may be synergistic when used in combination against bacteria difficult to eliminate, and are less likely to leave residual "persistent" organisms. Antagonism between chemotherapeutic agents is of little clinical importance.

The penicillins, cephalosporins, and cycloserine interfere with bacterial cell wall synthesis. Polymyxin, colistin, and nystatin affect the bacterial cell membrane. Protein manufacture by the bacterial ribosome is interfered with by the tetracyclines, chloramphenicol, erythromycin, and lincomycin, and the initiation of protein molecules by streptomycin. Streptomycin, kanamycin, and neomycin also cause the ribosome to manufacture warped proteins. Nalidixic acid, griseofulvin, and novobiocin upset the D.N.A. replication of the bacterial chromosome.

Many of the factors adverse to the success of chemotherapy are unimportant when powerful drugs are given in large doses to relatively fit patients infected with highly sensitive bacteria. But these factors become important when patients, particularly debilitated patients, are infected acutely or chronically with some of the more obstinate bacteria. Some grasp of these principles is therefore both intellectually satisfying and clinically useful.—John Crofton, M.D., Edinburgh, Scotland: *British Medical Journal,* 2:137-141, April 19, 1969.

Maternal Mortality Report For Ohio—1966

By the OSMA Committee on Maternal Health

THE Committee on Maternal Health presents its TWELFTH Annual Report in compliance with a House of Delegates directive adopted April 23, 1953, which created the Committee, and follow-up action taken by the OSMA Council, January 16, 1954.[1]

Five sections comprise this report, the first consisting of a resume of activities of your Committee since its last report to The Council in September, 1968.[2] The second portion describes various projects developed and pursued by the Committee in fulfilling its prescribed functions.

Section three presents a statistical summary of the Ohio Maternal Mortality Study for 1966* covering the 88 counties of Ohio, while the following portion analyzes the data. The reader will note that the data includes figures for patients who died *outside* of hospitals, as well as those who died during hospitalization. In the final part, recommendations are advanced by the Committee, based upon its experience in the study and allied facets.

Activities

The Committee on Maternal Health consists of 21 members representing the 11 Councilor Districts of Ohio. *Three* members, including the chairman, have been on the Committee since its inception in 1954. Four new members have been added since September, 1968 to replace members relieved of duty after various tours of *faithful* service. Our thanks to them! The *four* new members bring to the Committee expertise in anesthesia, internal medicine, obstetrics-gynecology, and pathology, respectively. Three skilled members convey a balance of experience from general practice to Committee sessions.

Three meetings have been held by the Committee since the last report to The Council. Besides conducting many items of important business, the Committee has studied, reviewed, and classified 75 maternal death cases. In the customary manner, "Guiding Principles for Obstetric Care"[3] was used as a minimum standard to assess avoidability in each case.

As this document goes to press, a fourth meeting is scheduled for January 17-18, 1970 at Granville, Ohio. The Committee will study this report before its presentation to The Council in addition to numerous other items on the agenda.

Each quarter-year, the Committee continues to publish an article in this column titled "Maternal Health in Ohio." Subjects include not only various primary causes of maternal death gleaned from cases in the Ohio Study, but also this annual report and other material (see Table 1).

Various members of the Committee have appeared on programs of several general and specialty groups to disseminate educational information gleaned from The Ohio Maternal Mortality Study; future invitations include the participation in the huge ACOG-FIGO Congress (New York City) April 13-18, 1970.

The Committee encourages and supports six well-established regional maternal mortality studies operated in Cleveland, Columbus, Cincinnati, Dayton, Toledo, and Akron. By collateral management and mutual agreement, "case" collection is more complete throughout the state, both intercounty and within the Ohio (State) Study.

Recently, the Columbus (Franklin County)

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

Maternal Mortality Study, founded by Drs. R. L. Meiling and A. Ruppersberg, celebrated its 21st consecutive year of operation, publishing the 21st annual survey in the local County Medical Society *Bulletin*.[4]

Documentation of the history and growth of the "Ohio Study," the "Franklin County Study," and others has been compiled and published in an excellent treatise by Marmol and associates.[5]

Projects

The data processing system compiling information from questionnaire forms to IBM cards continues to operate successfully. At this time, data from 1302 maternal cases have been transcribed to the cards for the first 12 years of The Ohio Maternal Mortality Study (1955-1967). Material is used from time to time to produce various educational programs (see Table 2). As the files of completed cases grow, more cases (both old and new) are added, to produce a wealth of data for information and education. Presently, plans are being established to convert IBM cards in our system for use with the computer. With this advent, expansion of the present program will be unlimited.

For the OSMA Annual Meeting in Columbus, May 12-16, 1969, the Committee prepared and presented a scientific exhibit entitled "Maternal Deaths Due to Criminal Abortion." Facts, features, and statistics derived from the "Ohio Study" were received with maximum interest by physicians attending the convention.

As this article goes to press, a subcommittee is preparing an exhibit for the Committee to be displayed at the annual OSMA meeting in Columbus, May 11-15, 1970. The title "Maternal Deaths Due to Cardiac Disease" is appropriate in the wake of a prevalence of the subject within the Ohio Study.

A new project is under development by members of the Committee. Known as "Maternal Health in Ohio, Ready Reference Cards," individual desk cards are being prepared on several more common obstetric emergency conditions. Briefly outlined are cardinal symptoms, signs, and diagnostic features, together with short details of specific treatment for each respective emergency. Originating in the Michigan Committee on Maternal Health, members of our Committee are revising the material for use by Ohio physicians who attend obstetric patients. When completed, the cards will be distributed free at the Committee's Exhibit Booth, OSMA Annual Meeting.

To date, all "projects" assigned or requested by The Council have been completed by the Committee.

Statistics from the Ohio Study for the year 1966 are published herewith. They are presented with uniformity to facilitate comparison with similar reports issued in the past and with those to appear in the future. Terminology and nomenclature used throughout the study were adopted in 1954, after careful study and deliberation. They follow closely those prescribed in the *International Classification*, for purposes of uniformity.

TABLE 1. Publication Date and Subject, "Maternal Health in Ohio Column," OSMJ Quarterly Issues, 1966 to 1970.

Date	Subject
Sept. 1968	Maternal Mort. Report for Ohio—1965
Dec. 1968	Maternal Deaths in Appalachia
Mar. 1969	Maternal Deaths Due to Cardiac Arrest After Spinal Anesthesia
June 1969	Maternal Deaths with Septic Shock After Criminal Abortion
Sept. 1969	Maternal Deaths from Hem., Due to Abruptio Placentae and Associated Afibrinogenemia
Dec. 1969	Maternal Deaths from Hem., Due to Ruptured Uterus, and Associated Afibrinogenemia

TABLE 2. IBM Data Processing Projects, By Number and Assignment, 18 Months, 1968 to 1970.

IBM Project	Assignment and Purpose
No. 60	Maternal Deaths After Abortion (1969 Exhibit)
No. 61	Maternal Mort. Report for Ohio—1966 (Council & OSMJ)
No. 62	Maternal Deaths from Ruptured Uterus (For Disc., Distr. V, ACOG, Niagara Falls, Ont.) (Also OSMJ)
*No. 63	Maternal Deaths Due to Cardiac Disease (1970 Exhibit, Project Begun in 1966, as Project No. 55)
*No. 64	Obstetric Hemorrhage, Frequency, Etiology, and Prevention of Deaths (Presentation Before Annual Meeting, Texas State Medical Association, May 1970)

*(In preparation)

Discussion

From the 1966 annual report, Ohio Department of Health, Division of Vital Statistics,[6] some interesting points are gleaned. The total resident population of Ohio was 10,691,488, an increase of 1.2 percent over 1965 at the same period (July 1). The total live births (190,444) represented a decline of 4,483 over the 1965 figure, the lowest since the year 1950; in 1966, 31,716 of the mothers were *under* the age of 20 years, and 49 percent of all illegitimate births were children born to mothers *under* 20 years of age. Nearly *eight percent* (7.9) of the live births (190,444) during 1966, were *premature* births (fetal weight less than 5 lb 8 ounces); there were 2,659 fetal

Ohio Maternal Mortality Study
Statistics for 1966

Total Live Births in Ohio, 1966		190,444
(Total Cases in files, 12 years, 1955-1966 .....1302)		
Total Cases Studied (1966)	79	
Cases not studied due to lack of information	3	
Undetermined	0	
Maternal Deaths (Classified)	52	
Non-white	14	
White	38	
Age:		
Teens	6	
20's	23	
30's	19	
40's	4	
Parity:		
Primigravidae	12	
Multiparae	37	
Unknown	3	
Place of Death:		
Hospital	43	
Home	7	
Other	2	
Type of Delivery:		
Not Recorded	1	
Operative	20	
Nonoperative (spontaneous)	14	
Not delivered	17	
Route of Delivery:		
Not recorded	1	
Vaginal	23	
Cesarean	9	
(antemortem)	9	
*(postmortem)	0	
Laparotomy (ectopic preg.)	2	
*Not delivered	17	
Case Classification (when death occurred):		
Not known	0	
Group I (fr. concept. to 20th wk.)	6	
Group II (fr. 20th wk. to 28th wk.)	2	
Group III (fr. 28th wk. through term)	9	
Group IV (postabortal, postpartum)	35	
Autopsies (includes 11 coroners' cases)	46	
Prenatal care (apparent from data sheets):		
None	3	
Unknown or not reported	7	
Adequate	25	
Inadequate	8	
Excluded (ectopic preg. and abortion)	9	
Classification of preventability:		
Nonpreventable	19	
Preventable (avoidable factor)	33	
Patient responsibility (P_1)	11	
Personnel responsibility (P_2)	18	
Both P_1 and P_2	3	
P_3 (Misc.)	1	

Classification of Primary Causes of Death

Hemorrhage		9
Abortion, without sepsis	0	
Abruptio	1	
Afibrinogenemia	2	
Abruptio	1	
Am. fl. embolus	0	
Dead fetus	0	
Ruptured uterus	1	
Atony, uterine, postpartum	0	
Ectopic pregnancy (without sepsis)	4	
Laceration, extrauterine	0	
Placenta Praevia	1	
Retained Placenta	1	
Ruptured uterus (no afibrin.)	0	
Other	0	
High Risk Related: 0 Non-Related: 3		
Infection		11
Abortion, alleged "criminal"	1	
Abortion, septic, spontaneous	2	
Up. Resp. Inf.	0	
Peritonitis	4	
Septicemia (puerperal sepsis)	3	
Septicemia (other)	0	
Other	1	
High Risk Related: 0 Non-Related: 6		
Toxemia		7
Acute yellow atrophy	0	
Hypertension, chronic (incl. hypertension with cerebrovascular hem.)	1	
Eclampsia	5	
Preeclampsia	0	
Puerperal toxemia, not specified	1	
High Risk Rated: 0 Non-Related: 3		
Other		25
Amniotic fl. emb. (no hemorrhage)	4	
Anesthesia	4	
(general)	2	
(regional)	2	
Cardiac disease	4	
Cerebrovascular hemorrhage (no tox.)	2	
Drug poisoning	1	
Liver disease	1	
Lower nephron nephrosis	1	
Pulmonary edema	2	
Pulmonary embolus	4	
Renal disease, chronic, unspecified	0	
Other	2	
High Risk Related: 0 Non-Related: 25		

In Ohio, there were 190,444 live births reported during 1966. From this maternal mortality study, the Committee classified 52 *maternal* deaths for the year. The maternal mortality rate was 0.27 per 1,000 live births, or 2.78 per 10,000 live births for 1966.

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deaths ("stillbirths") reported for 1966. Ohio Vital Statistics carried a total of 49 (resident) maternal deaths, with a rate of 2.6 per 10,000 live births.

Turning to the Ohio Maternal Mortality Study, a brief review of the statistics for 1966 reveals some additional figures of comparative interest. The Committee voted 52 of the 79 cases as maternal deaths. There were 42 in the 1965 Annual Report. In the age group of mothers dying, the greatest majority fell in the 20's; six were in the "teen age" segment. Twelve of the patients were primigravidae (there were only four in 1965); over twice the number (17) reported for 1965, *died undelivered.*

There were *five* ectopic pregnancies, two of which were operated upon before death; *four* of these died of hemorrhage, while one was "signed out" with "pulmonary embolism" as a primary cause of death.

Among the 52 maternal deaths, 46 autopsies

were performed; 11 of these were *coroner's* autopsies. Among 45 patients reported, prenatal care was considered *adequate* in 25; seventeen received inadequate prenatal care while three received *none*.

Using "Guiding Principles for Obstetric Care" as a guide,[3] 33 of the 52 patients were voted *preventable* maternal deaths; the majority of these were voted personnel responsibility.

As a major change from the usual trend, in the 1966 statistics, *infection* (11 cases) leads the list of primary causes of death (Fig.1) replacing its former leader, *hemorrhage* (9 cases). Once more, a former prevalent "killer," *toxemia* (7 cases) rises to prominence with *five* fatalities from *eclampsia!*

However, as a bizarre change, among the 52 maternal deaths, there were 25 patients who were "tagged" *HIGH RISK* for pregnancy before the terminal gestation; *NONE* of these "High Risk Conditions" was *related* to the cause of death, in any of the 25 patients!

Figure 1 also shows that "Other Causes" (25 deaths) now approximates the sum of the "Three Killers," hemorrhage, infection, and toxemia (27 deaths).

Recommendations

• 1. Again the Committee recommends the Ohio Maternal Mortality Study be continued in an effort to reduce maternal mortality and morbidity to an absolute minimum. Through augmentation of its research and education facilities, various direct and indirect factors related to individual maternal deaths may be evaluated, and disseminated to the "medical public."

• 2. Attempts should be made to support local education programs to improve prenatal care of pregnant women; to impress pregnant women with the importance of seeking prenatal care *early!* Specific programs involve both *physicians* and the *lay public!*

• 3. Council members have done well to support maternal death studies in their respective districts, as well as at "state level." Their interest is acknowledged; continuation of their support is recommended.

• 4. All queries and projects assigned to the Committee by The Council, having been completed, the Committee invites the submission of future problems related to "Maternal Health in Ohio."

• 5. Programs in county medical society meetings, hospital staff meetings, and selected meetings before lay groups offer excellent media for education. Program chairmen are invited to request members of the Committee to address groups; correspondence may be addressed to the Committee on Maternal Health, OSMA Headquarters, 17 South High Street, Columbus, Ohio 43215.

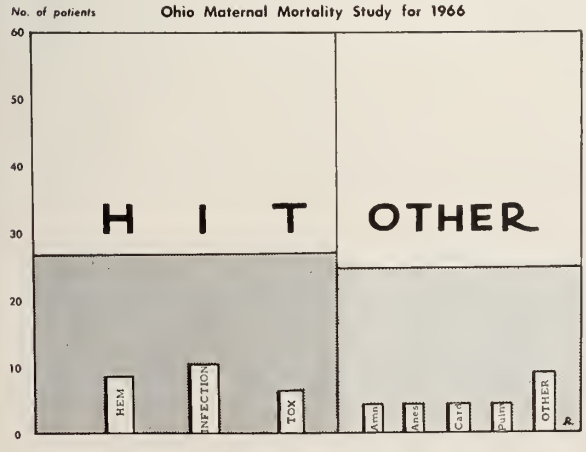


Fig. 1. Classification of primary causes of death, 52 maternal deaths for 1966

The Chairman takes this opportunity to express appreciation to members of the Committee for their loyal support and faithful discharge of assigned duties. Furthermore, the Committee gratefully acknowledges assistance provided by attending physicians, representatives of various county medical societies, the Ohio Department of Health, Association of Coroners, and numerous other agencies and individuals. Without their cooperation, this Maternal Mortality Study could not have reached completion.

Respectfully submitted,
ANTHONY RUPPERSBERG, JR., M.D.,
Chairman, Committee on Maternal Health

Approved by The Council of the Ohio State Medical Association, February 22, 1970.

References

1. Maternal Mortality Study, Statewide Basis. *Ohio State Med. J.*, 51:886-888 (Sept.) 1955.
2. OSMA Committee on Maternal Health: Maternal Mortality Report for Ohio — 1965. *Ohio State Med. J.*, 62:585-589 (June) 1966.
3. OSMA Committee on Maternal Health: Guiding Principles for Obstetric Care. *Ohio State Med. J.*, 53:1328-1329, 1957 (Revised, 63:1612-1614 (Dec.) 1967).
4. Franklin County Maternal Mortality Study Committee. Franklin County Maternal Mortality Study for 1968. *Bulletin, Academy of Medicine of Columbus and Franklin County*, 35:340-342 (Dec.) 1969.
5. Marmol, Jose G., et al. History of Maternal Mortality Study Committees in the U.S. *Obstet Gynec.* 34:123-138 (July) 1969.
6. Ohio Department of Health: Annual Report for 1966. *Ohio State Med. J.*, 63:1229-1230 (Sept.) 1967.



Professional Activities

Cincinnati Workshop Scheduled March 21 on Delivery of Health Care

A day-long workshop, March 21, on "The Delivery of Health Care," will be sponsored by six institutions broadly representative of various elements in the Cincinnati community. It will be held in William C. Procter Hall of the University of Cincinnati College of Nursing and Health.

The workshop will bring together consumers and health professionals to air problems of health care delivery and explore methods now available, including prepaid group practice.

Sponsors of the March 21 workshop are the Academy of Medicine of Cincinnati, AFL-CIO Labor Council, Blue Cross of Southwest Ohio, Health Planning Association of the Central Ohio River Valley, Ohio Valley Regional Medical Program, and University of Cincinnati College of Medicine.

Financial support for the workshop has come from the Health Services and Mental Health Administration of the U.S. Public Health Service.

Outstanding national and local health care leaders will present their points of view on health care delivery. These include Dr. Ernest Saward, of Portland, Ore., medical director of Permanente Medical Group; Dr. Frank H. Mayfield, past president of the Cincinnati Academy of Medicine and Ohio State Medical Association; Earl Kammer, president, Blue Cross Association of Southwest Ohio; Dr. Jerome Pollack, of Boston, associate dean for medical care planning, Harvard Medical School; Sam Pollock, Cleveland, president of Local No. 427, Meat Cutters Union; Robert P. Duvin, Cleveland, attorney and chairman of Cleveland Food Industry Committee.

Henry Russell, director of the Cincinnati Community Chest and Council, will be moderator. Summary of workshop reports will be given by Louis Segadelli, Washington, D.C., associate director of the Group Health Association of America.

Additional Medical Facilities at Ohio State Approved

The Ohio State University Board of Trustees recently acted on major construction projects for the campus.

The board approved plans and specifications for a university-affiliated Mental Retardation Facility for which federal grants and state appropriations total some $4.95 million.

It employed an architectural firm for planning and other services on an Ambulatory Patient Teaching Facility to be built in the university's Medical Center, and employed two engineering firms for services in planning an addition to Ohio State's present Dentistry Building.

Site of the four-story Mental Retardation Facility is east of Cannon Drive and north of Dodd Hall at the southwest corner of the Medical Center area in Columbus.

The building will provide facilities for care of the mentally retarded and for the interdisciplinary and interdepartmental preparation of professional personnel in the field of mental retardation.

Trustees approved employment of an architectural firm in planning and supervising construction of a proposed Ambulatory Patient Teaching Facility. This building is planned for the Medical Center area west of Perry Street and south of Means Hall.

1970 ANNUAL MEETING PROGRAM OUTLINE



SHERATON-COLUMBUS HOTEL
VETERANS MEMORIAL BUILDING
COLUMBUS

MAY 11-15, 1970

Ohio State Medical Association

1970 OSMA ANNUAL MEETING SCHEDULE

Sheraton-Columbus Hotel
(Headquarters Hotel)

Scientific Sessions and Exhibit Hall
Veterans Memorial Building

May 11, 12, 13, 14, and 15

MONDAY, MAY 11

3:00- 7:00 P.M.	Registration of Delegates, Alternates, OSMA Council and Official Guests	Terrestrial Promenade Second Floor Sheraton-Columbus
4:00 P.M.	Councilor District Caucus Meetings District 1 — Dr. Ivins — Room 401 District 2 — Dr. Schroer — Room 823 District 3 — Dr. Becker — Room 814 District 4 — Dr. Bates — Room 523 District 5 — Dr. Robechek — Room 501 District 6 — Dr. Lieber — Room 623 District 7 — Dr. Press — Room 514 District 8 — Dr. Wells — Room 701 District 9 — Dr. Clarke — Room 601 District 10 — Dr. McLarnan — Room 723 District 11 — Dr. Schultz — Room 614	Studio Rooms Sheraton Columbus
5:30 P.M.	Buffet Dinner for Delegates, Alternates, OSMA Council and Official Guests	Venus and Mars Rooms Second Floor Sheraton-Columbus
7:00 P.M.	First Session — Business Meeting OSMA House of Delegates	Saturn and Jupiter Rooms Second Floor Sheraton-Columbus
5:00 P.M.	Party given for VIP Women	French Pavilion Fourth Floor Sheraton-Columbus

TUESDAY, MAY 12

8:30-11:00 A.M.	Special Registration of Exhibitors	Veterans Memorial Bldg.
8:30 A.M.	General and Pre-registration	Veterans Memorial Bldg.
9:00 A.M.-12:30 P.M.	Athletic Injury Conference "The Health Team — For Better Athletics, Better Living"	Main Auditorium Veterans Memorial Bldg.
9:00 A.M.	Res. Committee No. 1	Auditorium, Third Floor Sheraton-Columbus
9:00 A.M.	Res. Committee No. 2	McKinley-Harding Rooms, Third Floor Sheraton-Columbus
9:00 A.M.	Res. Committee No. 3	Harrison Rooms Third Floor Sheraton-Columbus

ANNUAL MEETING SCHEDULE (Continued)

TUESDAY, MAY 12 (Continued)

9:00 A.M.	Committee on President's Address	Hayes-Garfield Rooms Third Floor Sheraton-Columbus
9:00 A.M.	Committee on Nominations	Grant Room Third Floor Sheraton-Columbus
9:30 A.M.	Section and Ohio Society of Pathologists	Room 201, Second Floor Veterans Memorial Bldg.
11:00 A.M.	Health Commissioners Institute Meeting with Director of Health	Room VM 22 Veterans Wing, Mezz. Veterans Memorial Bldg.
12:00 NOON	All Exhibits Open (Technical, Scientific and Health Education)	Veterans Memorial Bldg.
12:00 NOON	Orientation Session of new OSMA Members, "complimentary luncheon"	Assembly Hall First Floor Veterans Memorial Bldg.
1:00- 1:30 P.M.	Break for Tour of Exhibits	Veterans Memorial Bldg.
1:30 P.M.	Continuation of Reference Committee Meetings, if necessary	Sheraton-Columbus
1:30- 2:30 P.M.	OSMA General Session Speaker: Nick Dallis, M.D. "A Fictional Doctor Reveals What His Non-Fictional Patients Think About the Medical Profession"	Main Auditorium Veterans Memorial Bldg.
2:00 P.M.	Section and Ohio Society of Pathologists	Room 201, Second Floor Veterans Memorial Bldg.
2:30- 5:00 P.M.	School Health Conference "Growing Up With Sex Education"	Main Auditorium Veterans Memorial Bldg.
3:00 P.M.	Health Commissioners Institute	Room VM 22 Veterans Wing, Mezz. Veterans Memorial Bldg.
4:30 P.M.	Close Exhibits for Tuesday	Veterans Memorial Bldg.
EVENING	Ohio Division, Inc. American Cancer Society (Cocktails and Dinner)	Harrison Rooms Third Floor Sheraton-Columbus
6:00 P.M.	Health Commissioners Banquet	Neil House 41 South High St.
6:00- 8:30 P.M.	Ear, Nose and Throat Section and Ohio Ear, Nose and Throat Society Reception	McKinley-Harding Rooms, Third Floor Sheraton-Columbus

ANNUAL MEETING SCHEDULE (Continued)

WEDNESDAY, MAY 13		
8:30 A.M.	General and Pre-registration	Veterans Memorial Bldg.
9:00 A.M.	All Exhibits Open	Veterans Memorial Bldg.
9:00 A.M.-12:30 P.M.	General Session "12th Annual Cancer Conference" sponsored by the Ohio Division, Inc. American Cancer Society	Assembly Hall First Floor Veterans Memorial Bldg.
9:00 A.M.	Ohio Chapter, American College of Chest Physicians	Room 209 Second Floor Veterans Memorial Bldg.
9:00 A.M.	Section on Ear, Nose and Throat and Ohio Society of E.N.T.	Room 205, Second Floor Veterans Memorial Bldg.
10:00 A.M.	Ohio Chapter American Academy of Pediatrics (Executive Meeting)	Carribean Room Second Floor Sheraton-Columbus
10:00 A.M.	Ohio Ophthalmological Society Annual Business Meeting	Athletic Club of Columbus 136 East Broad St.
10:30-11:00 A.M.	Break for Tour of Exhibits	Veterans Memorial Bldg.
11:00 A.M.	Health Commissioners Institute	Room VM 22 Veterans Wing, Mezz. Veterans Memorial Bldg.
11:30 A.M.	OMPAC Luncheon Speaker: Mr. Robert D. Novak Washington, D.C. Washington Columnist and Author	Saturn Room, Second Floor Sheraton-Columbus
12:00 Noon	Ohio Chapter American Academy of Pediatrics Luncheon	Baltic and North Rooms Second Floor Sheraton-Columbus
12:00 Noon	Luncheon and Business Meeting Section on Rheumatology	Garfield-Hayes Room Second Floor Sheraton-Columbus
12:00 Noon	Luncheon Ear, Nose and Throat Society	China-Malay Room Second Floor Sheraton-Columbus
12:00 Noon	Ohio State Society of Thoracic Surgeons Luncheon and Business Meeting	Harrison Rooms Second Floor Sheraton-Columbus

(Continued on Page 279)



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Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the lutenizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates in the United States found relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives. This has not been confirmed in the United States.



Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for 2 months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted. anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: Increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

1. Royal College of General Practitioners: Oral Contraception and Thromboembolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967.
2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968.
3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969.
4. American Journal of Epidemiology (to be published).

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ANNUAL MEETING SCHEDULE (Continued)

WEDNESDAY, MAY 13 (Continued)

12:00 Noon	Ohio Ophthalmological Society Luncheon	Athletic Club of Columbus 136 East Broad St.
12:00 Noon	Section on Colon and Rectal Diseases Luncheon	University Club 40 South Third St.
1:30- 2:00 P.M.	Break for Tour of Exhibits	
2:00- 3:00 P.M.	OSMA GENERAL SESSION Speaker: Roger Egeberg, M.D.	Main Auditorium Veterans Memorial Bldg.
3:00 P.M.	Section on Anesthesiology	Room 202, Second Floor Veterans Memorial Bldg.
3:00 P.M.	Section on Colon and Rectal Diseases	Room 209, Second Floor Veterans Memorial Bldg.
3:00 P.M.	Section on Ear, Nose and Throat and Specialty Society	Room 205, Second Floor Veterans Memorial Bldg.
3:00 P.M.	Section on Internal Medicine	Rooms 203-204 Second Floor Veterans Memorial Bldg.
3:00 P.M.	Section on Obstetrics and Gynecology	Room 208, Second Floor Veterans Memorial Bldg.
3:00 P.M.	Section on Ophthalmology and the Ohio Ophthalmological Society	Rooms 206-207 Second Floor Veterans Memorial Bldg.
3:00 P.M.	Section and Chapter on Pediatrics	Room 201, Second Floor Veterans Memorial Bldg.
3:00 P.M.	Section on Rheumatology	Room 102, First Floor Veterans Memorial Bldg.
3:00 P.M.	Health Commissioners Institute	Room VM 22 Veterans Wing Mezz. Veterans Memorial Bldg.
4:30 P.M.	Close Exhibits for Wednesday	Veterans Memorial Bldg.
5:30 P.M.	Case Western Reserve Cocktail Party	Baltic-North Rooms Second Floor Sheraton-Columbus
7:00 P.M.	OSMA Social Function "FAR EAST FLING"	Celestial Ballroom Second Floor Sheraton-Columbus

ANNUAL MEETING SCHEDULE (Continued)

THURSDAY, MAY 14		
8:30 A.M.	General and Pre-registration	Veterans Memorial Bldg.
8:30 A.M.	Breakfast, Ohio Committee on Trauma, American College of Surgeons	The Oceanic Suite, Second Floor Sheraton-Columbus
9:00 A.M.	All Exhibits Open	Veterans Memorial Bldg.
9:00 A.M.	General Session "The Conquest of Hypertension— No Longer the Impossible Dream" Program sponsored by the Ohio State Heart Association	Assembly Hall, First Floor Veterans Memorial Bldg.
9:00 A.M.	Health Commissioners Institute	Room VM 22 Veterans Wing Mezz. Veterans Memorial Bldg.
9:00 A.M.	Section on Occupational Medicine	Room 205, Second Floor Veterans Memorial Bldg.
10:00 A.M.-12:00 Noon	Executive Committee Meeting, Ohio Committee on Trauma, American College of Surgeons	Grant Room Third Floor Sheraton-Columbus
10:30-11:00 A.M.	Break for Tours of Exhibits	Veterans Memorial Bldg.
11:00 A.M.	OSMA GENERAL SESSION Program sponsored by SAMA Chapters	Assembly Hall, First Floor Veterans Memorial Bldg.
12:00 Noon	Exhibitors Luncheon, Hosted by OSMA (Technical, Scientific and Health Education)	South Terrace, Ground Floor Veterans Memorial Bldg.
12:00 Noon	Luncheon for Committee on Scientific Work	South Terrace Ground Floor Veterans Memorial Bldg.
12:30 P.M.	Business Meeting, Section on Plastic Surgery	Room 102, First Floor Veterans Memorial Bldg.
1:00 P.M.	General Session Program sponsored by the Section on Plastic Surgery	Assembly Hall, First Floor Veterans Memorial Bldg.

ANNUAL MEETING SCHEDULE (Continued)

THURSDAY, MAY 14 (Continued)

1:30 P.M.	Section and Ohio Neurosurgical Society	Room 205, Second Floor Veterans Memorial Bldg.
2:00 P.M.	OSMA GENERAL SESSION Speaker—Dr. Norman Vincent Peale	Main Auditorium First Floor Veterans Memorial Bldg.
3:00- 3:30 P.M.	Break for Tour of Exhibits	Veterans Memorial Bldg.
3:30- 5:00 P.M.	General Session "The Practical Management of Emergency Room Emergencies" Program presented by the Ohio Committee on Trauma, American College of Surgeons	Assembly Hall, First Floor Veterans Memorial Bldg.
3:30 P.M.	Combined Section on Directors of Medical Education and Section on General Practice	Room 201, Second Floor Veterans Memorial Bldg.
3:30 P.M.	Section on Physical Medicine and Rehabilitation	Rooms 203-204, Second Floor Veterans Memorial Bldg.
4:30 P.M.	Dismantle all Exhibits	Veterans Memorial Bldg.
5:30 P.M.	Buffet Dinner (Delegates, Alternates, OSMA Officers and Official Guests)	Mars and Venus Rooms, Second Floor Sheraton-Columbus
6:00 P.M.	Dinner Physical Medicine and Rehabilitation	(place to be determined)
6:30 P.M.	Registration—Final Session of House of Delegates	Terrestrial Promenade, Second Floor Sheraton-Columbus
7:00 P.M.	Business Meeting, Final Session of the House of Delegates	Jupiter and Saturn Rooms, Second Floor Sheraton-Columbus

FRIDAY, MAY 15

7:30 A.M.	OSMA Council Meeting (To be held following House of Delegate Meeting)	Grant Room, Third Floor Sheraton-Columbus
9:00 A.M.	Meeting of the OSMA Delegates and Alternates to the AMA	Harrison Rooms, Third Floor Sheraton-Columbus

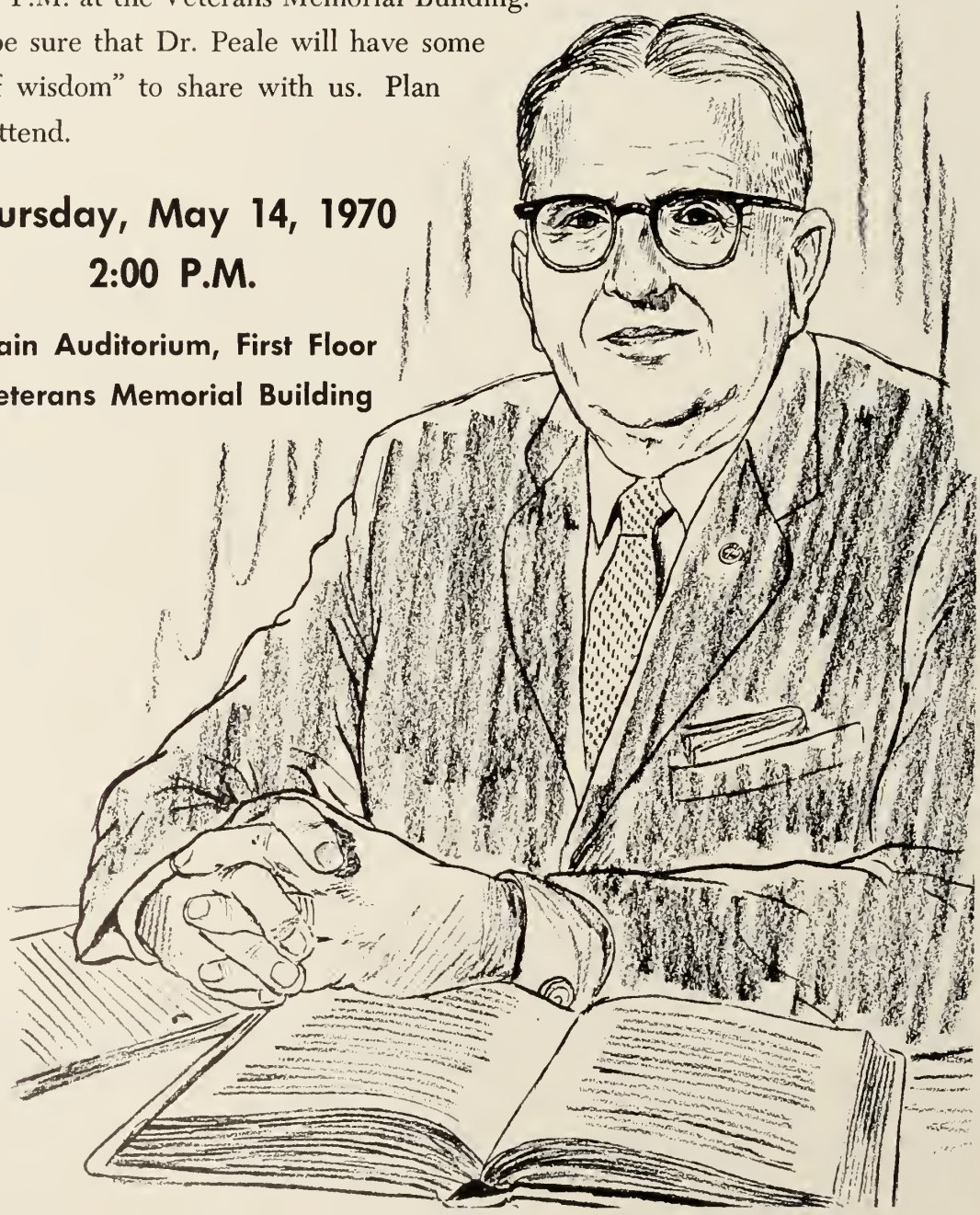
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almost synonymous with the name DR. NORMAN VINCENT PEALE. Probably no other minister of our time has a more far-flung pulpit than Dr. Peale. Through his books, radio and television programs, speeches and published sermons he has reached and is reaching millions of people throughout the world.

We are privileged to have this former Ohioan as our OSMA General Session speaker on Thursday, May 14 at 2:00 P.M. at the Veterans Memorial Building. We can be sure that Dr. Peale will have some "words of wisdom" to share with us. Plan now to attend.

Thursday, May 14, 1970
2:00 P.M.

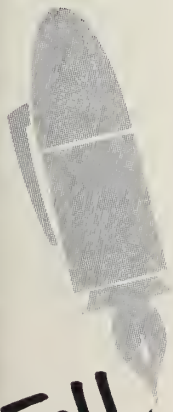
Main Auditorium, First Floor
Veterans Memorial Building



Remember: REGISTER NOW... AVOID LONG LINES SAVE TIME...



Remember the convenience of pre-registration last year? No long lines, no fumbling for your credentials, everything for the meeting in one envelope. It did save time, didn't it? It was so successful that we will be offering this service again this year. In case you have forgotten the procedure, HERE IS HOW IT WORKS – after OSMA receives your PRE-REGISTRATION FORM we will check membership and fill out your registration card. We will then make a badge for you and your wife if you have indicated that she will be attending, place your badge, program and requested social function tickets and luncheon tickets in an envelope in your name. Then all you need to do is come to the PRE-REGISTRATION DESK and ask for your envelope in your name and you are ready to visit the exhibits and attend the meetings of your choice. Make ONE STOP do it, you will be glad you did!!!



Fill It Out

PRE-REGISTRATION FORM

1970 Annual Meeting
Columbus, Ohio

Ohio State Medical Association
May 11 - 15, 1970

Name _____
(Please Print)

Address _____
(Number and Street) (City) (Stote)

I am:

- ☐ OSMA Member
- ☐ Official OSMA Delegate
- ☐ Official OSMA Alternate
- ☐ Non-member Physician
- ☐ Guest
- ☐ Medical Student
- ☐ Scientific Exhibitor
- ☐ Executive Secretary
- ☐ News Media

Please prepare guest badge for my spouse.

_____
(Pleose Print Nome)

— SOCIAL FUNCTION TICKETS —
RESERVATIONS

Nate: (Na tickets reserved without money)

Make checks payable ta:
Ohia State Medical Association

Mail this farm ta:
Ohia State Medicol Associotion
17 South High Street, Suite 500
Calumbus, Ohio 43215

Wednesday, May 13, 1970 — 11:30 A.M.
"OMPAC Luncheon" Number
Sheraton-Columbus Hotel
$5.00 per person .....

Wednesday, May 13, 1970 — 7:00 P.M.
"Far Eost Fling"
Sheraton-Columbus Hotel
$12.00 per persan .....

Thursday, May 14, 1970 — 12:00 Noon
"Exhibitars Luncheon"
Veterans Memarial Building
$4.00 per persan .....
(Complimentory ta Exhibitors)

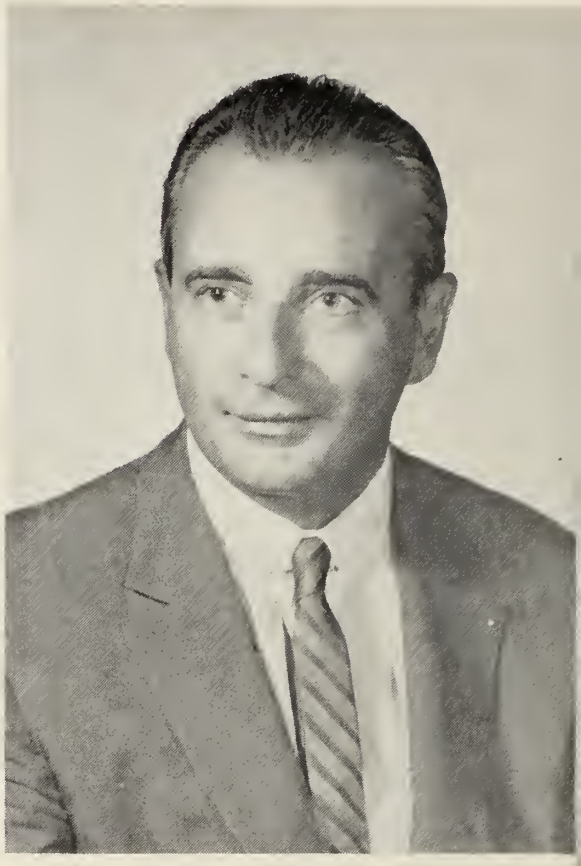
MAIL IT TODAY



DID YOU KNOW??

On May 10, 1970, Rex Morgan, M.D., will have been in practice 22 years.





NICHOLAS P. DALLIS, M.D.

His practice, of course, has been limited to the comic pages of some 400 newspapers in the U.S. and Canada, and in 35 Foreign countries.

The author, NICHOLAS P. DALLIS, M.D., former Toledo physician turned full time author of three comic strips, i.e., Rex Morgan, M.D., Judge Parker and Apt. 3-G will share "what his non-fictional patients think about the Medical Profession."

Many Toledo, Ohio people will remember Dr. Dallis as a practicing psychiatrist in the Toledo area for 15 years. Make it a must to attend this GENERAL SESSION on TUESDAY, MAY 12 at 1:30 P.M., VETERANS MEMORIAL BUILDING.

The Title of Dr. Dallis' presentation will be...

"A Fictional Doctor Reveals What his Non-Fictional Patients Think About the Medical Profession"



OSMA GENERAL SESSION SPECIAL

WEDNESDAY, MAY 13, 1970
2:00 P.M.

Main Auditorium, Veterans Memorial Building

ROGER O. EGEBERG, M.D.

ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS
Department of Health, Education, and Welfare
Washington, D.C.

We are fortunate to have a former Ohioan take time from his busy schedule to speak to Ohio physicians. We invite YOU to be present from 2:00 p.m. - 3:00 p.m. and hear what Dr. Egeberg has to share with us. Many of you will remember that Dr. Egeberg was in private practice in Cleveland, Ohio for a number of years.



AVOID THE RUSH...
MAKE YOUR HOTEL RESERVATIONS TODAY!



MAKE YOUR HOTEL RESERVATIONS FOR THE 1970 OSMA ANNUAL MEETING

Columbus May 11 - 15

Leading Downtown Columbus Hotels at Prevailing Rates

Sheraton-Columbus Motor Hotel
50 North Third Street
(OSMA Headquarters)

Singles	$15.00 - $20.00
Doubles	$20.00 - $25.00
Twins	$20.00 - $25.00

Neil House Motor Hotel
41 South High Street

Singles	$11.00 - $19.00
Doubles	$14.00 - $18.00
Twins	$15.00 - $23.00

Southern Hotel
South High and East Main Streets

Singles	$10.00 - $15.00
Doubles	$13.50 - $15.00
Twins	$14.00 - $17.00

Holiday Inn-Downtown
175 East Town Street

Singles	$13.50
Doubles	$18.50
Twins	$18.50

Christopher Inn
300 East Broad St.
(Woman's Auxiliary Headquarters)

Singles	$13.50 - $15.00
Doubles	$18.00
Twins	$20.00

Pick-Fort Hayes Hotel
31 West Spring Street

Singles	$12.00 - $17.00
Doubles	$16.00 - $20.00
Twins	$16.00 - $20.00

All rates subject to change.

If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK
(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____Columbus, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 11 - 15 (or for period indicated).

_____Single Room _____Twin Room

_____Double Room Other Accommodations _____

Price Range_____

Arrival: May_____ at _____ A.M. _____ P.M.

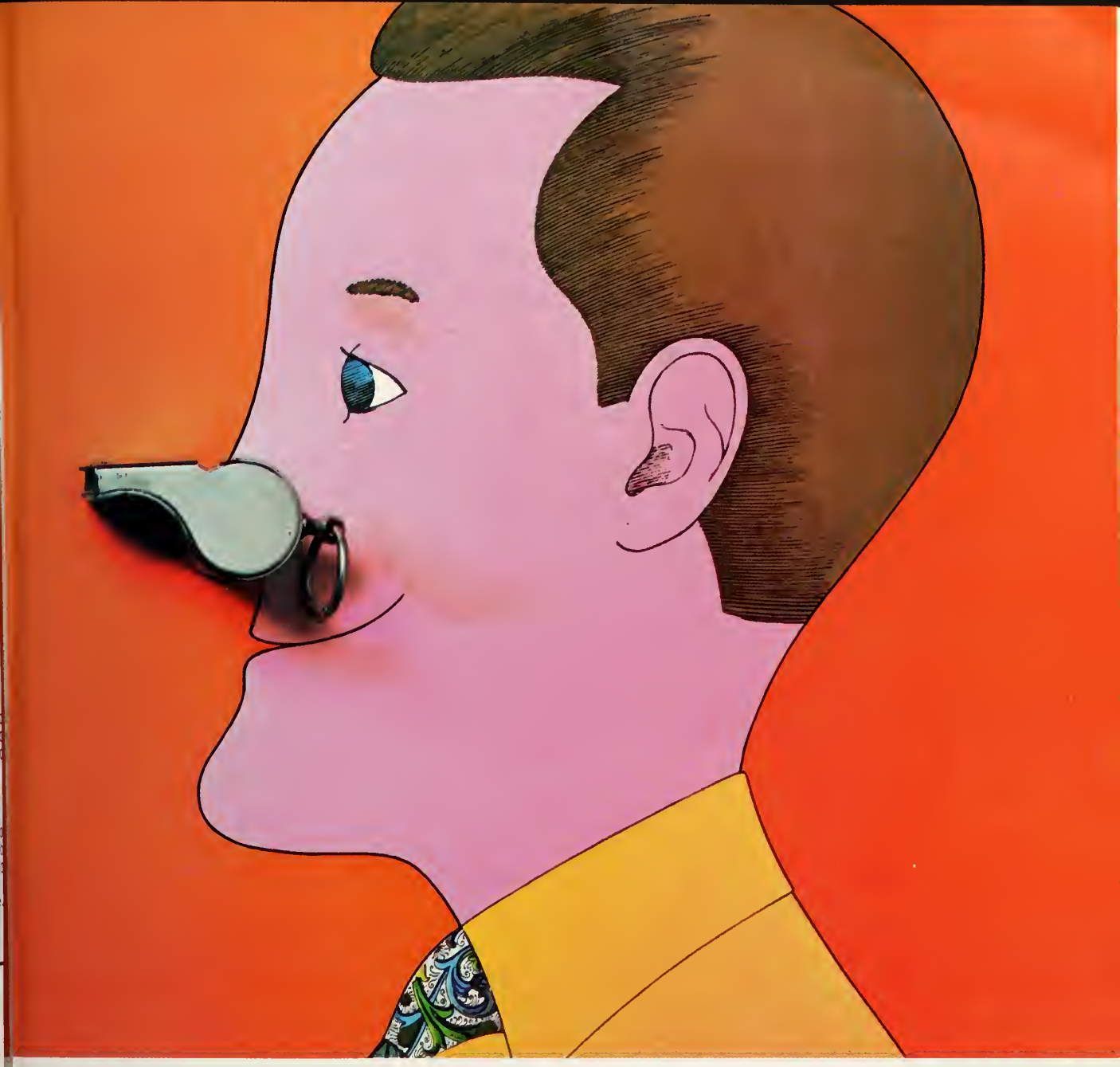
Departure: May_____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION

Name_____

Address_____

_____



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

Hasn't the driver had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.



Driver Escapes Serious Injury When Truck Jackknifes

SHENANDOAH, JULY 16. Roger Sherman of Waynesboro suffered head lacerations but escaped serious injury when the tractor-trailer he was driving skidded on Deep Run Bridge and jackknifed. It took rescue workers thirty minutes to remove him from the cab which was dangling over the edge of the bridge. Sherman is resting comfortably in University Hospital where his condition is listed as satisfactory.

Frankhouser called my attenti

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg. Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg. Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Ohio Physician Named to AMA Health Services Post

Dr. Effie O. Ellis, Ohioan and nationally known for her work with the health and nutritional problems of the poor, joined the American Medical Association February 1 in an important new post.

According to E. B. Howard, M.D., AMA Executive Vice-President, Dr. Ellis will report directly to him as Special Assistant for Health Services. The position is newly created.

Dr. Ellis, of Columbus, Ohio, served as the director of maternal and child health for the Ohio State Department of Health.

Commenting on the appointment, Dr. Howard said, "The AMA is extremely fortunate to have Dr. Ellis in this important new post. The insight that she brings to the activities of the AMA's Committee on Health Care of the Poor, as well as in many other areas of concern, will be of vital importance.

"The AMA has a commitment to do everything in its power to meet the health care needs of every American," Dr. Howard said. "Dr. Ellis will bring to us a wealth of knowledge and experience about the special needs of the disadvantaged."

Dr. Ellis has served the Federal government in a number of capacities, most recently as chairman of a panel group at the 1969 White House Conference on Food and Nutrition. She has also served in the Department of Health, Education and Welfare as its first Regional Commissioner for Social and Rehabilitation Service, and Regional Medical Director of HEW's Children's Bureau, both in Midwest Region Five.

Earlier, Dr. Ellis, a native of Georgia, served the Ohio Health Department as a pediatrics consultant.

For more than eight years, Dr. Ellis was director of medical education and house pediatrician at Provident Hospital, in downtown Baltimore, Md. It was here, Dr. Ellis said, that she first became familiar with the specialized health care needs of the poor.

She also serves on state advisory committees for crippled children and school health, and is active in the Association for Maternal and Child Health. Family planning is one of her major concerns.



Dr. Ellis

A graduate of Atlanta's Spelman College, Dr. Ellis has a master's degree in biology from Atlanta University. She is a graduate of the University of Illinois Medical School and served her internship there at University Hospital. She also served a pediatrics residency at Massachusetts General Hospital and did additional pediatrics work at Johns Hopkins University Medical School.

Disabled Veterans' Special Insurance Available

The Veterans Administration has called attention to the fact that thousands of disabled veterans are not taking advantage of low-cost insurance available to them.

Administrator of Veterans Affairs Donald E. Johnson said that VA disability ratings result in more than 7,000 veterans being added to the rolls each month. When they are, Johnson said, they are encouraged to apply for the special RH insurance with low premiums. As an example of the rate, a 25-year-old veteran can start a $10,000 insurance program for $2.60 a month.

RH National Service Life Insurance is available to veterans separated from service after April 24, 1951, who have been rated by the VA as having a service-connected disability.

Applications for RH insurance must be submitted within one year from the date VA establishes the disability.

Proposed Revisions in the Constitution and Bylaws of the Ohio State Medical Association

TO: MEMBERS OF THE OHIO STATE MEDICAL ASSOCIATION

AT THE DIRECTION of 1969 House of Delegates of the Ohio State Medical Association, President Smith appointed a committee for the purpose of a general review and revision of the Constitution and Bylaws of the OSMA, with instructions for the committee to report its findings and recommendations at the 1970 session of the House.

This committee consists of Dr. James McLarnan, Councilor of the Tenth District; Dr. Homer Anderson, Chairman of the Judicial and Professional Relations Committee; and Dr. Richard Fulton, President-Elect of OSMA. The Committee was assisted by Dr. Robert Smith, OSMA President, Mr. Hart Page, Executive Secretary, and Mr. Wayne Stichter, Legal Counsel.

The text which follows this introduction is the Constitution and Bylaws containing the committee's proposed revisions.

It is realized that many members of the Association will not be particularly interested in every detail of the revision. However, there are certain items that the committee feels are definitely worthy of particular emphasis and that should be read by members. In an attempt to save the readers' time, I shall denote certain areas of revision in the hope that all members will read these important changes.

CONSTITUTION

Article I, Section 2 — Purposes: This section has been greatly enlarged. It denotes the multiple purposes of OSMA and should be read by all. It presents the purposes in much more detail than the original Article 2.

Article II, Section 1 — Definition of Component Societies; and **Section 2 — Geographical Scope:** Section 1 is not significantly changed, but Section 2, regarding geographical scope, is changed radically from the previous Constitution. With this revision it would be possible for a county society with a small number of physicians to split its membership, a portion of the members affiliating with one adjoining county, and the others joining another adjacent county. This is a new concept and a revision that the committee feels is important.

Article III — Classes of Members: For years the Constitution has stated that the Association has "one class of members." This revised wording is more practical since it includes all of the various classes. All OSMA members should read this part.

Article IV — House of Delegates: This article has been changed considerably and the new text is much more inclusive than that of the previous article.

Article V, Section 3 — The procedure for calling special meetings is better defined than in the old Constitution.

Article VI: Under this revision, the Treasurer will be known as the Secretary-Treasurer.

Article X — Referendum: The text of this article is much more detailed than the previous wording. This revision represents a great deal of time and effort and the committee feels that the new version clarifies this procedure and could prove a useful tool in the operation of the organization.

BYLAWS

Chapter 1, Section 2 — Classification of Membership: As stated before, the various classes of membership have been identified and this section deals with the definition of each classification.

Chapter 3 — Annual Meeting: The former designation "Scientific Assembly" has been changed to "Annual Meeting." The entire contents of this chapter has been drastically changed, and the committee feels that the procedure will be much more practical and workable as rewritten.

Chapter 4, Section 2: This section has also been greatly expanded and the committee feels is much clearer as rewritten.

Chapter 4, Section 4: At the end of this section it is stated that "The President shall appoint from the roster of alternate delegates the Committee on Tellers and Judges of Election." This procedure was felt to be appropriate. Often, if numerous ballots must be counted, the delegates serving on this committee miss much of the discussion and other important information during their absence. It was felt that if this committee were composed of alternate delegates, time of the delegates would be conserved.

Chapter 4, Setion 9, A — Opening Session: Many more activities have been included in the opening session in the hope that more time can

be devoted to the main order of business at the final session, reports of reference committees.

Chapter 4, Section 9, B — Final Session of the House of Delegates: It should be noted that election of candidates has been placed early in the final session. Should numerous ballots be necessary, counting can be done while reports of reference committees are being made. The committee feels that this is a very time-conserving measure.

Chapter 6, Section 1 — President: In this revised section it is stated that if the office of President shall become vacant the Immediate Past President shall succeed to the presidency. This procedure is an innovation and one that the committee believes is much more practical than having the President-Elect take over a year ahead of schedule.

Chapter 6, Section 3 — Secretary-Treasurer: Secretary-Treasurer is a new name for the officer previously designated the Treasurer only. It would be well for members to read this section.

Chapter 6, Section 4 — Executive Director: The title "Executive Secretary" has been changed to "Executive Director." The latter is much more descriptive for the holder of this office since he is director of a rather large staff and should be acknowledged as such.

Chapter 6, Section 5 — Immediate Past President: This section states that the Immediate Past President, as well as all past presidents of the Association shall have the right of the floor for discussion at all meetings of the House of Delegates. The committee feels that this is an honor that should be bestowed upon the Association's past presidents.

Chapter 7, Section 1 — Powers and Duties of the Council: This entire chapter has been greatly expanded to make more definite the duties of the OSMA Council. The revised section doesn't change the powers and duties to any extent, but merely spells them out in more detail.

Chapter 9 — Committees: Prior to this revision there were only four standing committees. The revision adds the fifth, the "Committee on Membership and Planning." There is a definite need and an important funtion open to this committee during the next few years.

The committee appointed by Dr. Smith felt a responsibility to make the revised Constitution and Bylaws simpler, more explanatory, and more workable. It is hoped that members will consider primarily the principles involved in the revision and minimize minutia. Comments, of course, are welcome and may be made at the Annual Meeting when the revised Constitution and Bylaws is up for consideration. One of the reference committees will devote its entire time to this revision so that members can be heard adequately. The committee has tried to make the revision practical and not too fancy. Members of the committee will be glad to answer questions at the Annual Meeting.

Richard L. Fulton, M.D., Chairman
Committee to Revise the Constitution and Bylaws

Constitution and Bylaws of the Ohio State Medical Association

CONSTITUTION

ARTICLE I

NAME AND PURPOSES

Section 1. Name. The name and title of this corporation shall be OHIO STATE MEDICAL ASSOCIATION.

Section 2. Purposes. The purposes of this Association shall be:

(1) To bring into one organization the physicians of the State of Ohio and through this and similar societies of other states to maintain and support the American Medical Association.

(2) To formulate and maintain educational programs designed to provide better service to the public in matters of personal and public health.

(3) To encourage among members of the medical profession the interchange of views on all phases of medical science to the end that each member of the profession may be better equipped to serve society and promote the health of the public.

(4) To maintain programs of scientific education keyed to the constant advancement of the science of medicine and to foster, encourage, and coordinate postgraduate educational facilities for the medical profession as a whole.

(5) To disseminate, among members of the profession, by means of scientific publications and otherwise, information reflecting advances in medical research.

(6) To maintain and advance the standards of medical practice in this state by requiring strict adherence by the members of the profession to the highest concepts of professional ethics.

(7) To carry on such functions and activities as are deemed necessary or desirable to effectuate the above purposes; provided, however, that the Association shall not engage in any activities which cannot be construed as relevant, incidental, or necessary to its charitable, educational, or scientific purposes.

(8) To study and formulate methods of health care delivery with particular emphasis on efficiency and availability.

ARTICLE II

COMPONENT SOCIETIES

Section 1. Definition. Component societies shall consist of those county medical societies which now hold, or may hereafter receive, charters from this Association.

Section 2. Geographical Scope. Not more than one component society shall be chartered in any one county; provided, however, that a charter may be granted to a society comprising two or more counties, or parts thereof, when, in the judgment of the House of Delegates, the chartering of a multi-county society

is in the best interests of this Association; and provided further, that whenever two or more component societies holding charters from this Association shall request in writing that they be organized into a single multi-county society, the House of Delegates may grant a charter to such multi-county society, such multi-county society to be officially designated by hyphenating the names of the counties comprising such multi-county organization.

Section 3. Membership in Adjoining Society. If there should be an insufficient number of physicians in any county to form themselves into a component county society, such physicians may become members of the component society of an adjoining county if they are otherwise eligible under the Constitution and Bylaws of such adjoining component society.

ARTICLE III

COMPOSITION OF THE ASSOCIATION

Section 1. Classes of Members. The Association shall consist of the following classes of members:

1. Active Members (including retired active members)
2. Associate Members
3. Resident and Intern Members
4. Non-resident Members
5. Honorary Members
6. Military Members

Section 2. Voting Members. The voting members of this Association shall consist of each of those physician members of the component societies who has complied with the eligibility requirements of Chapter 1 of the Bylaws of this Association, and who has been certified by the appropriate officer of his component society as being an active member in good standing of such society, and whose dues and assessments in this Association for the current year have been received at the headquarters of this Association; provided, however, that the foregoing provision regarding receipt of dues and assessments shall not apply to members exempted from the payment of dues and assessments under the provisions of Chapter 2 of the Bylaws of this Association, or to members whose dues and assessments have been waived.

ARTICLE IV

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) delegates elected by the component societies; (2) officers of the Association enumerated in Article VI; (3) such representatives of other medical groups as may be determined by the House of Delegates; (4) delegates and alternate delegates to the AMA from Ohio and Past Presidents of this Association each of whom shall be an ex-officio member without right to vote unless such delegate, alternate delegate or past president be a duly elected delegate from a component society or a duly elected officer of this Association.

ARTICLE V

MEETINGS

Section 1. Annual Meeting. This Association shall hold an Annual Meeting during which there shall be sessions of the House of Delegates, general sessions, meetings of specialty sections and meetings of specialty societies, all of which shall be open to all registered members and registered guests.

Section 2. Time and Place of Annual Meeting. The time and place for holding each Annual Meeting shall be fixed by the Council of this Association.

Section 3. Special Meetings. Special meetings of the House of Delegates shall be called by the President or other officer upon a two-thirds vote of the Council or upon the filing with the Executive Director of this Association of a petition duly authorized and signed by the governing bodies of at least thirty (30) component societies. Within ten days after such action of the Council, or the filing of such petition, the Executive Director shall give written notice to the members of the House of Delegates, setting forth the purpose or purposes of such called meeting and specifying the time and place thereof, which time of meeting shall in no event be less than twenty (20) days nor more than sixty (60) days after the mailing of such written notice.

ARTICLE VI

OFFICERS

Section 1. General. The officers of this Association shall be a President, a President-Elect, the Immediate Past President, a Secretary-Treasurer, and Councilors.

Section 2. Election and Eligibility. The officers of this Association shall be elected by the House of Delegates during the Annual Meeting. No person shall be eligible to an elective office who has not been a member of this Association during the entire preceding two years. The terms of the officers of this Association shall be such as are prescribed by Chapter 6 of the Bylaws of this Association.

ARTICLE VII

THE COUNCIL

The Council shall consist of one councilor from each councilor district and the other elected officers of this Association. The Council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

ARTICLE VIII

FISCAL YEAR

The fiscal year of this Association shall begin on January 1 and end on December 31.

ARTICLE IX

SEAL

This Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates in conformity with the laws of the State of Ohio.

ARTICLE X

REFERENDUM

By a two-thirds vote of the delegates present at a meeting of the House of Delegates, a general referendum shall be held upon any question then pending before it; and upon a petition duly authorized and signed by the governing bodies of at least one-half of the component societies and filed with the Executive Director on or before the thirtieth (30th) day following the adjournment of a meeting of the House of Delegates, a general referendum shall be held upon any action taken at such meeting.

The procedure to be followed in connection with the submission to a referendum of any referred question or action shall be that set forth in Chapter 14 of the Bylaws of this Association; provided, however, that if the referred question be with respect to a proposed amendment to this Constitution an affirmative vote of two-thirds (⅔) of those voting in such referendum shall be required to determine the referred question; and provided, further, that if the referred action of the House

of Delegates be with respect to the adoption by the House of Delegates of an amendment to this Constitution a vote of two-thirds (⅔) of those voting in such referendum shall be required to reject and nullify the action of the House of Delegates in adopting such amendment.

ARTICLE XI

Section 1. Method of Amending. The House of Delegates may amend any article of this Constitution by a two-thirds (⅔) vote of the delegates and officers registered at the Annual Meeting or at any special meeting called for that purpose; provided, however, that such proposed amendment shall have been published in *The Journal* of this Association at least sixty (60) days before such meeting and that a true and correct copy thereof shall have been sent officially to the secretary of each component society at least thirty (30) days before each meeting.

Section 2. Conformity by Component Societies. When an amendment to this Constitution has been duly adopted, the secretary of each component society shall be notified in writing by the Executive Director within sixty (60) days after such amendment has become effective. It shall become incumbent upon each component society to make such change in its constitution and bylaws, or, if the society be a corporation, in its articles of incorporation and code of regulations or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the Constitution of this Association. The secretary of such component society shall file with this Association a copy of such changes in the component society's constitution and bylaws together with written notice of compliance with the provisions of this section within one hundred and eighty (180) days after notice shall have been given by the Executive Director to such component society.

ARTICLE XII

Upon the adoption of this Constitution by a two-thirds (⅔) vote of the delegates and officers present and voting, this Constitution will become effective and thereupon all previous Constitutions shall be rendered null, void and of no effect.

BYLAWS

CHAPTER 1

MEMBERSHIP

Section 1. Rights of Members. All members in good standing of this Association shall have the right to attend all meetings of the Association and to take part in all the scientific proceedings of the Annual Meeting.

Section 2. Classification of Membership.

(a) Active Members. Active Members of this Association shall comprise all the active members in good standing of the several component societies. Only Active Members in good standing of this Association shall have the right to vote and hold office.

(b) Associate Members. Associate Members of this Association shall comprise all those members in good standing of the several component societies who hold an associate membership, or other probationary or provisional type of membership of limited duration, in a component society.

(c) Resident and Intern Members. Resident and Intern Members of this Association shall comprise all those members in good standing of the several component societies who are hospital residents and interns currently in active training within the State of Ohio.

(d) Nonresident Members. Nonresident members shall comprise those former or present active members of this Association who have changed their residence to outside Ohio and desire to maintain membership in this Association, who have been elected to nonresident membership, and whose dues and assessments in this Association for the current year have been paid.

(e) Honorary Members. The House of Delegates may elect as an Honorary Member any person distinguished for his services or attainments in medicine or the allied sciences or who has rendered other services of unusual value to medicine. An Honorary Member shall pay no dues or assessments.

(f) Military Members. Military Members comprise all those Active Members of this Association in good standing who are serving a limited tour of active duty with the Armed Services of the United States.

Section 3. Eligibility. To be eligible for any class of membership other than honorary in this Association, a person shall possess all of the following qualifications, to wit:

(a) He must be a citizen of the United States,

OR

He must have resided in the United States for at least one year, and within a period of three years prior to the date of the filing of his application for membership in a component society he must have filed in an appropriate court of record a declaration of his intention to become a citizen of the United States, which declaration has not been withdrawn.

(NOTE: See Section 6 of this Chapter 1 as to effect of failure of a member to obtain United States citizenship.)

(b) He must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, issued by the licensing authority of the State of Ohio, which license must be in full force and effect at the time of his application for membership in this Association.

OR

If he is currently serving as a hospital intern or resident within the State of Ohio and is not a member of a medical society of the District of Columbia or of any state or territory of the United States, he must be licensed to practice medicine and surgery by the licensing authority of the District of Columbia or of some state or territory of the United States.

(c) He must be a member in good standing of a component society.

Section 4. Disqualification. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from such society's roll of members, shall be entitled to any of the rights or benefits of this Association.

Section 5. Effect of Expiration, Revocation, or Termination of Certificate. Membership in this Association of a member whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be canceled automatically as of the effective date of such expiration, revocation or termination.

Section 6. Effect of Failure to Acquire United States Citizenship. Membership in this Association of a noncitizen of the United States who has failed to acquire United States citizenship within a period of five years from the date of the filing in an appropriate court of record of his declaration of intention to become a citizen of the United States shall be cancelled automatically on the date of the expiration of such five year period or on January 1, 1974 whichever date is later.

Section 7. Disciplinary Procedure. Disciplinary ac-

tion may be taken by this Association against a member of this Association only upon written charges signed by three or more members of this Association and filed with the Executive Director. As soon as possible, and in any event not later than ten (10) days after such filing, the Executive Director shall serve upon the accused member a true copy of such charges and shall also furnish to each member of the Council a copy thereof. Within thirty (30) days thereafter, the Council shall fix a time and place for a hearing on said charges and the Executive Director shall serve prompt written notice of such time and place upon the accused member and shall also furnish to each member of the Council a copy of such notice. Such hearing shall be held as soon as practicable but in no event sooner than twenty (20) days, or later than sixty (60) days, after the date of service of such notice upon the accused member. Service upon the accused of a copy of such charges or of such written notice, or both, may be made by delivering the same personally to the accused, or by sending the same both by registered mail and by regular mail addressed to the accused at his usual place of residence.

At the hearing upon such charges the accused shall be afforded full opportunity to be heard in his own defense, to be represented by *legal* counsel of his own choosing, to cross-examine the witnesses who testify against him, and to examine witnesses and offer evidence in his own behalf. The hearing shall be held and conducted in such manner as to ascertain all the facts fairly to the accused and this Association without requiring compliance with those formal or technical rules and requirements which ordinarily pertain to judicial proceedings.

Failure of the accused to appear or be represented at the hearing may be considered prima facie evidence of the truth of the charges.

A record shall be made of such hearing, and at the request of either the accused member or the Council, the Executive Director shall cause a transcript to be made of the proceedings and evidence and shall furnish to the accused member upon request a copy of such record without charge to the accused member. Following the conclusion of the evidence, the Council shall hear arguments of the parties and their counsel and may permit or require the filing briefs.

The decision of the Council shall be final and shall be binding on the accused member and this Association.

Section 8. Exculpatory Provision. No person against whom disciplinary action is instituted pursuant to the provisions of this Chapter 1 shall have any claim or cause against this Association or a component society or against any officer, Councilor or member of such Association or society, by reason of the institution, prosecution or disposition of such charges or the hearing or consideration thereof.

CHAPTER 2

DUES AND ASSESSMENTS

Section 1. Determination of Dues. The annual dues and assessments of Active Members and Associate Members of this Association shall be determined by the House of Delegates, and shall be levied per capita on such members. They shall be payable before January 1 of the calendar year for which such dues are levied. The dues and assessments shall be collected by the designated officer of each component society and shall be forwarded to the headquarters of this Association, together with such data as shall be required by this Association for its own record of such society's officers and membership.

The Council of this Association shall have the authority to promulgate regulations governing the amount of annual dues and assessments of all classifications of members other than Active and Associate.

A physician who is not engaged in active practice because of disability or the infirmities of age and who was a member in good standing of this Association at the time of his retirement from active practice shall be exempt from the payment of dues and assessments in this Association, provided he requests such exemption and such request is approved in writing by the secretary of his component society.

A member of this Association for whom payment of his regular dues in this Association constitutes a financial hardship may request the Council of this Association for an adjustment of dues. Such request shall be in writing, signed by such member and filed with the secretary of such member's component society. If such society, or the council of such society, finds that payment by such member of his regular dues in this Association shall constitute a financial hardship and certifies such finding to the Council of this Association, the Council of this Association will make such adjustment of his OSMA dues for such period of time, and subject to such conditions, as such Council may deem appropriate and advisable.

Section 2. Receipt of Dues, Qualifying Membership. The record of payment of dues and assessments on file in the offices of this Association shall be evidence of the fact of payment by a member and of his right to attend all meetings of the Association and to participate in all the scientific proceedings of the Annual Meeting.

Section 3. Arrears in Membership. A member of this Association whose dues and assessments in this Association shall not have been paid to the secretary of his component society on or before January 1 of any year shall be deemed delinquent from January 1 of such year and until such dues and assessments have been paid.

Section 4. Penalty for Failure to Remit. Any component society which fails to forward to the headquarters of this Association on or before the thirtieth (30th) day preceding the Annual Meeting such dues and assessments in this Association as the society may have collected shall be subject to the suspension of all its rights and privileges under its charter, in which case none of its members or delegates shall be permitted to participate in any of the proceedings of this Association or of the House of Delegates.

Section 5. Exemption from Dues and Assessments. The provisions of Section 2 and 3 of this Chapter shall not apply to members exempted from the payment of dues and assessments, or to members whose dues and assessments are waived.

CHAPTER 3

ANNUAL MEETING

Section 1. Functions of Annual Meeting. The Annual Meeting of the Association will be held as provided in Article V of the Constitution. This shall encompass the Scientific Assembly, the House of Delegates meetings and such other functions as may be determined by the Council.

Section 2. Registration. Each member in attendance at the Annual Meeting shall register, after his status as a member in good standing has been verified by reference to the records of this Association.

The name of a physician upon the membership roster of this Association shall be prima facie evidence of his right to register.

No member or delegate shall take part in any of

the proceedings of the Annual Meeting until he has registered.

Section 3. Scientific Program. The Scientific Assembly shall meet in such general sessions and such section sessions during the Annual Meeting as may be determined by the Committee on Scientific Work with the approval of the Council.

Section 4. Section Officers. Each section shall elect a chairman and a secretary to serve until their successors are elected. They shall serve as ex-officio members of the Committee on Scientific Work provided for in Section 4 of Chapter 9 of these Bylaws.

If for any reason a section shall fail to elect section officers at a section session held during the Annual Meeting, such officers shall be appointed by the Council at its first meeting following the close of the Annual Meeting.

Section 5. Section Sessions. Each section authorized by the Council shall hold its session or sessions at times determined by the Council but no section session shall be held at the same time as a general session.

Section 6. Acceptance of Papers. The papers and discussions in section meetings shall be limited to scientific subjects. No paper shall be presented before a section unless an abstract of such paper containing not less than thirty (30) and not more than one hundred and fifty (150) words, be in the hands of the Committee on Scientific Work at least thirty (30) days before the first day of the Annual Meeting.

Section 7. Section Rules. Rules adopted by a section must not be in conflict with the Constitution and Bylaws of this Association and must be approved by the Council before becoming effective.

Section 8. Time Limit of Papers. The Committee on Scientific Work shall each year fix a time limit for the delivery of each paper.

Section 9. Papers the Property of the Association. All papers read before this Association shall be its property and immediately after being read shall be deposited with the secretary of the section, if read before a section, or with the Executive Director, if read before a general session.

Unless express consent of the Council is first obtained, no member shall cause a paper read before this Association, or any part, abstract or summary thereof, to be published elsewhere prior to publication in the official *Journal* of this Association; and each guest speaker invited to read or deliver a paper on a medical or scientific subject shall be expected to agree, at the time of his acceptance of such invitation, to refrain from causing such paper to be published elsewhere prior to publication in such *Journal.*

CHAPTER 4

THE HOUSE OF DELEGATES

Section 1. Meetings of House of Delegates. The House of Delegates shall meet annually at the time and place of the Annual Meeting of this Association.

Section 2. Ratio of Representation. Each component society shall be entitled to one delegate in the House of Delegates for each one hundred (100) Active and Associate Members, or fraction thereof, in good standing in this Association; provided, however, that each component society shall be entitled to at least one delegate and one alternate delegate. The names of such delegates and alternate delegates shall be submitted to the headquarters of this Association at least thirty (30) days prior to the first day of the meeting of the House of Delegates.

In case of the absence or inability to serve of a delegate or alternate delegate of a component society, the president or secretary of such society may at any time certify to the Chairman of the Committee on Credentials the name or names of an Active Member or Members in good standing to serve in the place of such absent delegate or absent alternate delegate.

The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place and stead of such absent delegate or alternate delegate.

Section 3. Quorum. A majority of registered delegates and officers of this Association shall constitute a quorum. All sessions of the House of Delegates shall be open to all members in good standing of this Association.

Section 4. Committees of the House of Delegates. For the purpose of expediting proceedings the President shall appoint from the roster of delegates the following reference committees: Committee on President's Address and President-Elect's Address; Committees on Resolutions, to which shall be referred all resolutions (except those of an ethical nature involving professional relations, which shall be referred to the Council without discussion); Committee on Credentials; and other committees considered necessary by the President.

The President shall appoint from the roster of alternate delegates the Committee on Tellers and Judges of Election.

Section 5. Delegates to the American Medical Association. The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body.

Section 6. Councilor Districts. The House of Delegates shall establish councilor districts. A district society may be organized in any of the councilor districts to meet at such time or times as such society may fix, provided the dates chosen do not fall within a period of two weeks preceding or two weeks following the Annual Meeting of this Association.

The presidents of the component societies in the several councilor districts shall be vice-presidents of their respective district societies.

Section 7. Special Committees. Any voting member who is in good standing in this Association may be appointed to serve on any committee created for a special purpose. All members of committees who are not members of the House of Delegates shall have the right to present their reports to the House in person and to participate in the debate thereon, but shall not have the right to vote.

Section 8. Resolutions. Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements of filing and transmittal shall have been complied with or unless such compliance shall have been waived or dispensed with by vote of at least two-third (⅔) of the Delegates present at such meeting.

The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates such resolutions as the President or the Council may designate.

No consideration may be given, or any action

taken, by the Committee on Resolutions or by the House of Delegates, with respect to any resolution unless such resolution shall have been presented or introduced at the opening session of the meeting of the House of Delegates; provided, however, that a resolution dealing with an event or development occurring too late to permit the introduction of any such resolution at the opening session may be introduced at a later session with the consent of at least four-fifths (4/5) of the delegates present; and upon its introduction, such resolution shall be referred to the Committee on Resolutions for consideration and report; and, provided further, that the Committee on Resolutions shall have the right to amend any resolution presented or introduced, or to draft a composite or substitute resolution embracing the same subject matter as that contained in a resolution or resolutions presented or introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates, and the House of Delegates shall have the right to adopt any such amended, composite or substitute resolution.

Section 9. Order of Business. The following shall be the order of business for the opening and final sessions of the House of Delegates:

A. Opening Session.
1. Call to order by the President.
2. Report of Committee on Credentials.
3. Consideration of minutes of last Annual Meeting and of minutes of any special meeting of the House of Delegates held since the last Annual Meeting.
4. Introduction of special guests.
5. Appointment of Reference Committees by the President.
6. Election of Committee on Nominations.
7. Report of Special and Standing Committees.
8. President's Address.
9. Introduction of Presidents of other State Societies.
10. President-Elect's Address.
11. Introduction of Resolutions.
12. Miscellaneous business.

B. Final Session.
1. Report of Committee on Credentials.
2. Election of President-Elect.
3. Report of Committee on Nominations; and election of other officers.
4. Reports of Reference Committees.
5. Miscellaneous business.
6. Installation of officers.
7. Announcement of Committee Appointments by newly installed President and action thereon by House of Delegates.
8. Unfinished business.
9. Adjournment.

The order of business may be modified for any session by the presiding officer with consent of the House of Delegates.

CHAPTER 5

NOMINATION AND ELECTION OF OFFICERS

Section 1. Committee on Nominations. On the first day of the Annual Meeting the House of Delegates shall elect a Committee on Nominations consisting of one delegate from each councilor district. The chairmanship of the Committee on Nominations shall be rotated in numerical order annually among the Councilor district representatives on such Committee. The Committee on Nominations shall report to the House of Delegates a ticket containing the name of one or more members for each of the offices to be filled at that Annual Meeting except that of President-Elect. Prior to selecting a ticket the Committee shall hold hearings which shall be open to all members in good standing of this Association. Any member in good standing shall have the opportunity to appear before the Committee regarding any proposed candidate. The Committee may request an interview with any proposed candidate or with any member concerning such proposed candidate's qualifications. Each nominee must have a majority vote of the Committee in order to be placed on the ticket for presentation to the House of Delegates. Each nominee for Councilor must be a resident of the councilor district for which he is nominated. Delegates and Alternate Delegates to the AMA shall be elected at large.

Section 2. Eligibility for Reelection of Officers. No Past President of this Association shall be eligible for election as President-Elect. No Secretary-Treasurer shall serve for more than two consecutive terms. No Councilor shall serve in such capacity for more than three consecutive terms. Any officer originally elected to serve a year or less of an unexpired term shall not be regarded thereby as having served a term.

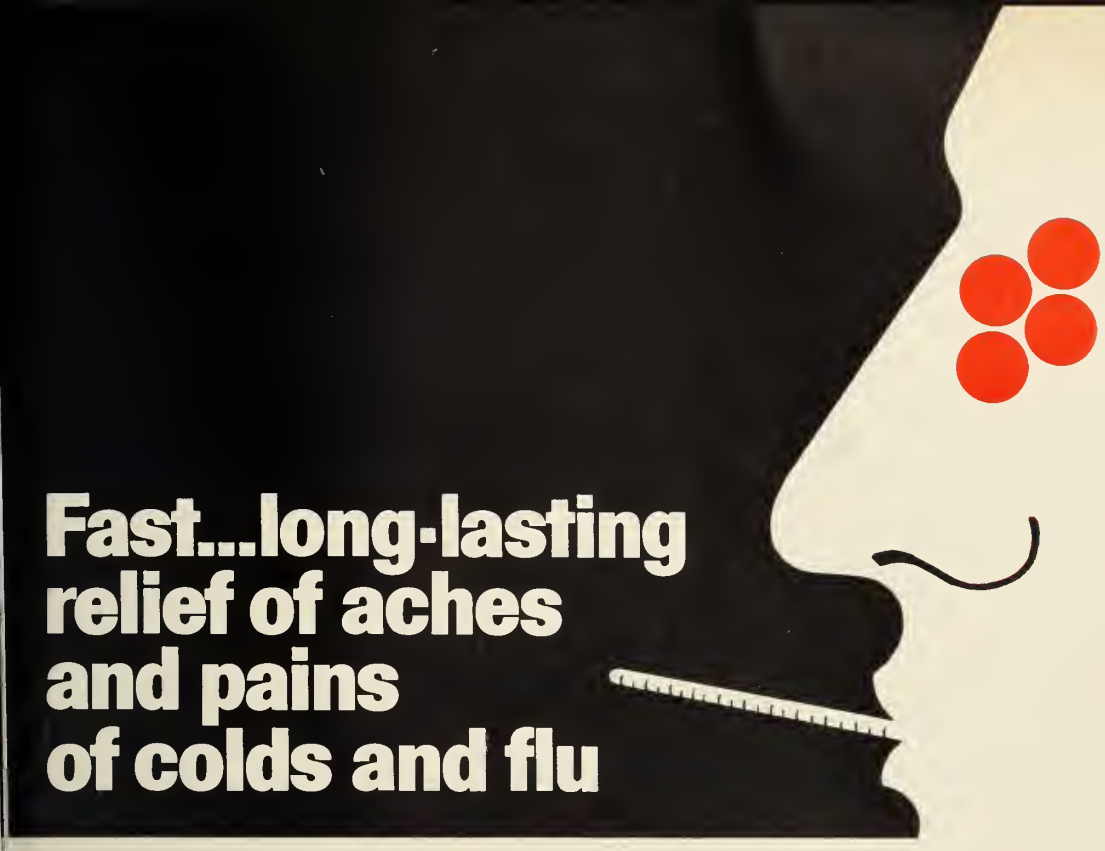
Nothing in these Bylaws shall be construed as forbidding later reelection to any office, other than that of President or President-Elect, after an interruption in consecutive service.

Section 3. Nomination of President-Elect. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (⅔) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal.

Section 4. Nomination of Officers and of Delegates and Alternate Delegates to the American Medical Association. The report of the Committee on Nominations with respect to all offices except that of President-Elect and with respect to all Delegates and Alternate Delegates to the American Medical Association, shall be posted at the registration desk of the Association at the earliest time practicable and at least three hours before the final session of the House of Delegates. Nominations for the office of President-Elect shall be made from the floor at the final session of the House of Delegates.

Each nominating speech for any office shall be limited to three minutes. Not more than one speech shall be made in seconding a given nomination and such seconding speech shall be limited to one minute.

Section 5. Election of Officers and of Delegates and Alternate Delegates to the American Medical Association. All elections shall be by ballot. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes



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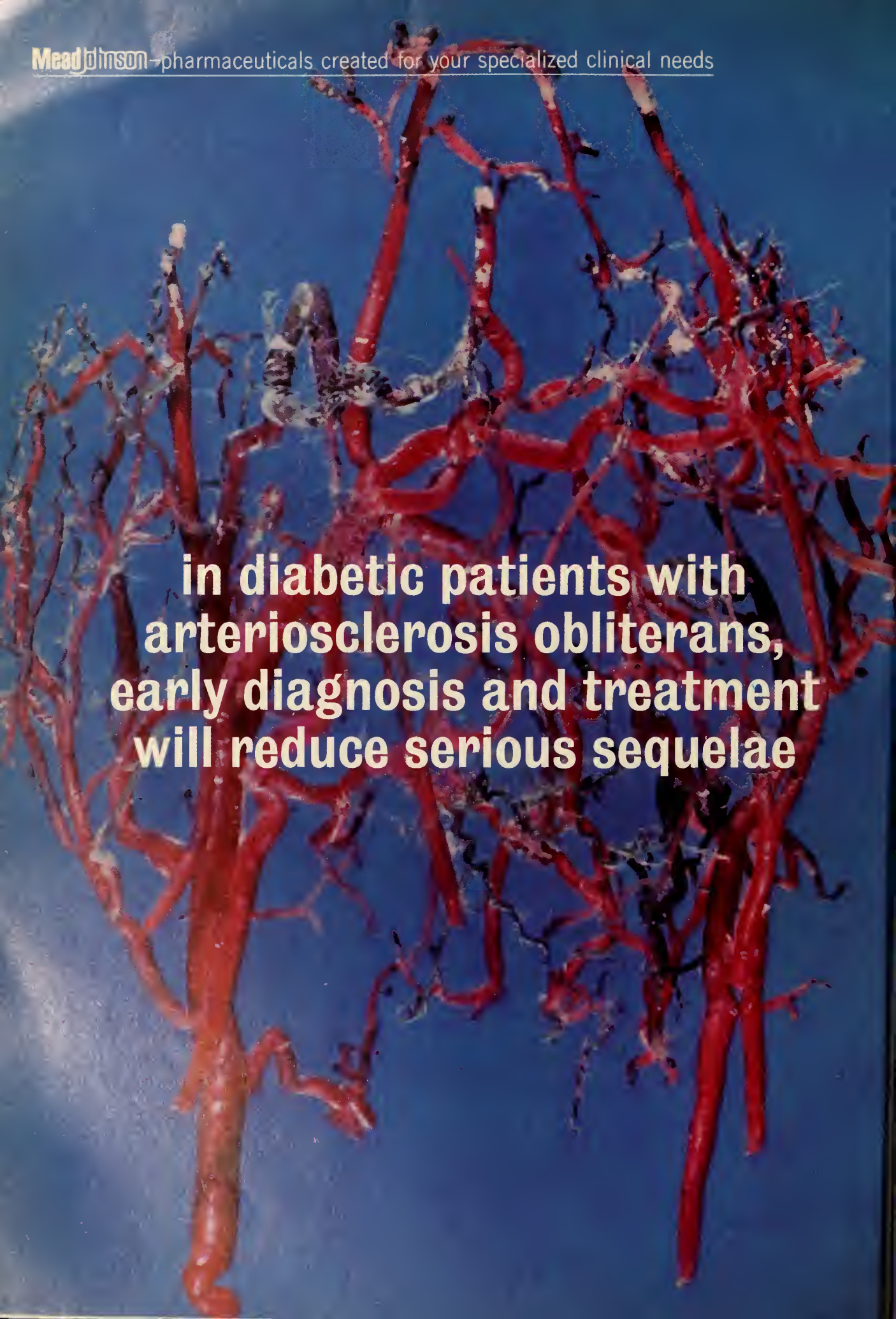
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References: (1) Stein, I.D.: Angiology *15*:1 (April) 1964. (2) New Drugs–Evaluated by the A.M.A. Council on Drugs, Chicago, American Medical Association, 1967, pp. 295-297. (3) Samuels, S. S., and Shaftel, H. E.: J. Indiana M. A. *54*:1021-1023 (July) 1961. (4) Kaindl, F.; Pärtan, J., and Polsterer, P.: Wien.klin.Wchnschr. *68*:186-191 (March 16) 1956. (5) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H.: Angiology *10*:185-192 (Aug.) 1959. (6) Myers, K. A.: Modern Treatment *4*:370-383 (March) 1967. (7) Gillespie, J. A.: Angiology *17*:280-288 (May) 1966. (8) Smit, Arne, F., *et al.*: Nordisk Medicin *20*:1260, 1959. (9) Samuels, S. S., and Shaftel, H. E.: JAMA *171*:142-145 (Sept. 12) 1959. (10) Frieh, C., and Olivier, L.: Lyon Med. *91*:891-896 (May 24) 1959. (11) Weghaupt, Von K.: Wien.klin.Wchnschr. 69:31-32 (Jan. 11) 1957. (12) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960.

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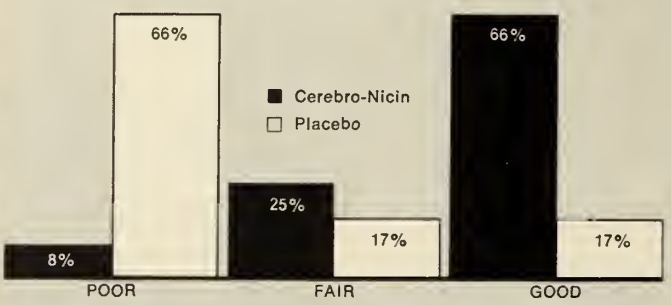
rophoto of occluded vessels in grenous area of a first toe utated because of severe arterio- rosis obliterans. Cast was made njecting acrylic plastic into the els. *Used with permission. Cour- of Margaret C. Conrad, Ph.D., artment of Physiology, Bowman- y School of Medicine, Wake st College, Winston-Salem, N. C.*

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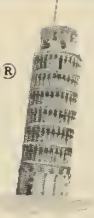
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Fertility and Sterility, January 197
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Contraindications – Methyltestosterone is not to be used in malignancy of reproductive organs in coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the meta rate is low.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of impotence. Clin Med 12:69, 1966. **2. Dublin, M F.** Treatment of impotence with methyltestoste thyroid compound. West Med 5:67, 1964. **3 Titeft, A. S.** Methyltestosterone-thyroid in treating impot Gen Prac 25:6, 1962 **4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher,** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 1 1959. **5. Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and triothyronine on spermatoge J Urol 79:863, 1958 **6. Osol, A., and Farrar, C. E.** United States Dispensatory (ed. 25). Lippincott delphia, 1955, p. 1432. **7. Wershub, L. P.** Sexual impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all votes cast, whereupon he shall be declared elected.

Section 6. Nominations from the Floor. Nothing in this chapter shall be construed to prevent additional nominations from the floor by delegates.

Section 7. Removal from Office. Any officer of this Association, or any delegate to the American Medical Association, or any alternate delegate to the American Medical Association, may be removed from office, for cause, at any time.

Proceedings for the removal from office of an officer of this Association or any delegate or alternate delegate to the American Medical Association shall be commenced by the filing with the Executive Director of this Association of a written complaint signed by not less than sixty delegates to the House of Delegates of this Association from at least thirty component societies. Such complaint shall name the person sought to be removed, shall state the cause for removal, and shall demand that a meeting of the House of Delegates be held for the purpose of conducting a hearing on the charges set forth in the complaint, and for the purpose of selecting an individual to fill the office which may be vacated by reason of the removal from office of the person sought to be removed.

Within ten (10) days after the filing of such complaint, the Executive Director shall serve upon the person named in such complaint a true and correct copy of such complaint, together with a written notice specifying the time and place of hearing the charges set forth in such complaint. The Executive Director shall also mail a copy of such complaint and notice to each delegate to the House of Delegates of this Association.

Service upon the person named in such complaint of a copy of the complaint together with such written notice shall be made by delivering the same personally to such person or by sending the same by certified mail addressed to such person at his usual place of residence.

At the hearing upon such charges the person named in such complaint shall be afforded full opportunity to be heard in his own defense, to be represented by counsel of his own choosing, to cross-examine the witnesses who testify against him, and to examine witnesses and offer evidence in his own behalf.

The House of Delegates shall convene for the purposes of hearing the charges in such complaint, and electing a successor, if need be:

(a) on any date during the Annual Meeting of the House of Delegates, provided the date of such Annual Meeting is more than thirty (30) and less than sixty (60) days subsequent to the date of the service of such written notice upon such person sought to be removed; or

(b) at a special meeting called for the purpose of hearing the charges set forth in such complaint, which special meeting shall be held on a date more than thirty (30) and less than sixty (60) days subsequent to the date of the service of such written notice upon such person sought to be removed.

A quorum shall consist of two-thirds (⅔) of the elected delegates.

If two-thirds (⅔) of the delegates of the House of Delegates present and voting by secret ballot vote affirmatively to remove such person from office, such person shall be declared removed from office.

A successor to an office in which a vacancy has been created as a result of the removal from office of any such officer, delegate or alternate delegate shall be elected to serve the balance of the term of such office. All nominations for such office shall be made from the floor. The election of a successor officer, delegate or alternate delegate shall be by a majority of the delegates present and voting and shall be in accordance with Section 5 of Chapter 5 of the Bylaws of this Association, and with respect to a successor delegate or alternate delegate to the American Medical Association such election shall also be in accordance with Section 5 of Chapter 4 of the Bylaws of this Association.

CHAPTER 6

DUTIES AND TERMS OF OFFICERS

Section 1. President. The President shall preside at all general sessions of this Association and sessions of the House of Delegates. He shall appoint all committees for the selection of which other provision is not made. He shall deliver an annual address at a session of the House of Delegates. He shall be chairman of the Council and shall perform such other duties as pertain to the principal administrative officer of a corporation. He shall be an ex-officio member of all committees of this Association. As Immediate Past President he shall be a member of Council for a period of one year immediately following his term of office as President. If the office of President shall become vacant, the Immediate Past President shall succeed to the Presidency and complete the unexpired term of such office; and in the event of the refusal or inability of the Immediate Past President to fill such vacancy, the President-Elect shall succeed to the Presidency and serve out the balance of such unexpired term.

Section 2. President-Elect. The President-Elect shall be a member of the Council and an ex-officio member of each standing committee, of the Auditing and Appropriations Committee, and of each special or other committee appointed by the President. He shall assume the duties of the President during the absence or disability of the latter. If the office of President shall become vacant and the Immediate Past President shall refuse or be unable to fill such vacancy, the President-Elect shall serve as President during the balance of the unexpired term and thereafter during the term for which the President-Elect was elected.

Section 3. Secretary-Treasurer. The Secretary-Treasurer shall receive all funds due this Association from every source whatever, except current accounts due *The Journal* in the conduct of its business. He shall deposit and keep the funds of this Association in a bank or banks of deposit approved by the Council. He shall keep a complete set of books concerning the receipts and expenditures of this Association, except those of *The Journal*. He shall have the duty to make such purchases, sales, leases, acquisitions or dispositions of real and personal property as may be ordered or authorized by the Council and to execute on behalf of this Association, all documents and papers which may be required in connection with any such purchases, sales, leases, acquisitions or dispositions. He shall pay money out of the treasury upon vouchers as directed by the Auditing and Appropriations Committee, rendering a monthly trial balance of his accounts to each member of Council. At the expense of this Association he shall give bond in such amount as shall be required by the Council.

The Secretary-Treasurer shall be a member of Council and an ex-officio member of the Auditing and Appropriations Committee.

Section 4. Executive Director. The Executive Director shall be appointed by the Council. He shall be ex-officio the secretary of this Association, of its Council,

and of all its committees. He shall be the executive agent of this Association and shall transact its business under the direction of its officers. He shall collect, through the secretaries of the component societies, dues for membership in this Association and dues for membership in the American Medical Association and he shall remit to the Secretary-Treasurer of this Association all collected dues for membership in this Association and shall remit to the secretary of the American Medical Association all collected dues for membership in that association.

He shall be the managing editor and business manager of *The Journal.* He shall pay over the excess of receipts over expenses, if any, of *The Journal* to the Secretary-Treasurer at the end of each fiscal year, or whenever ordered to do so by the Auditing and Appropriations Committee or the House of Delegates. Whenever the income of *The Journal* does not meet its expenses, he shall make requisition with the approval of the Auditing and Appropriations Committee and the Council, on the Secretary-Treasurer for the necessary funds.

He shall have charge of the business offices of this Association and may employ such aid as shall be authorized by the Council. He shall be the custodian of all books and papers belonging to this Association except those of the Secretary-Treasurer.

He shall provide for the registration of the members at the Annual Meeting and shall provide for reporting the proceedings of the Annual Meeting. He shall conduct the official correspondence, notifying members of meetings, officers of their election, committees of their appointments and duties, and he shall perform such other duties as may be assigned to him by the President or the Council. At the expense of this Association he shall give bond in such amount as shall be required by the Council.

Section 5. Immediate Past President. The Immediate Past President shall be a member of the Council for a period of one year immediately following his term of office as President, and during such period he shall be an ex-officio member of each standing committee, of the Auditing and Appropriations Committee, and of each special or other committee appointed by the President. The Immediate Past President, as well as all Past Presidents of this Association, shall have the right of the floor for discussion at all meetings of the House of Delegates.

Section 6. Terms of Officers. The President shall serve one year and shall be succeeded by the President-Elect. The term of office of the Secretary-Treasurer shall be for three years. The term of office of Councilors shall be for two years; Councilors of the odd-numbered districts shall be elected at annual meetings held in even-numbered years; and Councilors of the even-numbered districts shall be elected in odd-numbered years. All these officers shall serve until their successors are elected and qualified.

For the purposes of this section, the period from one Annual Meeting until the next shall be regarded as one year.

CHAPTER 7

THE COUNCIL

Section 1. Powers and Duties of the Council. The Council shall be the executive body of this Association. Between meetings of the House of Delegates, the Council shall have and exercise all the powers and authority conferred on the House of Delegates by the Constitution and these Bylaws. In the exercise of the interim powers thus conferred upon it, the Council shall take no action contravening any general policy which shall have been adopted by the House of Delegates and which is then in effect.

The Council shall have direction of the investment and reinvestment of the funds of this Association.

The Council shall determine the character and scope of the scientific proceedings of this Association and at least thirty (30) days prior to each Annual Meeting, it shall issue a program announcing the order in which papers and discussions are to be presented.

The Council shall be the board of censors of this Association, considering all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates shall be referred to the Council without discussion. The Council shall have full power and authority to hear and decide all questions of discipline affecting the conduct of the members of this Association or the conduct of a component society. Its decisions in all cases, including questions regarding the right of membership in this Association, shall be final.

The Council shall provide for and superintend the issuance of *The Ohio State Medical Journal,* referred to herein otherwise as *The Journal.* It shall have full power and authority to appoint a medical editor or publication board, or both, and make any other provisions for the publication of *The Journal* which in its judgment are feasible including full discretionary power: (1) to promulgate rules and regulations governing the publication of *The Journal;* (2) to enumerate and define the powers and duties of the medical editor or publication board, or both; and (3) to fix the terms and conditions of their appointment.

The Council shall have full power and authority to employ an Executive Director, who need not be a physician or member of this Association, and to employ such other employees as the Council may deem necessary or advisable.

The Council shall provide such offices for the headquarters of this Association as may be required properly to conduct its business.

Section 2. Council Meetings. The Council shall hold meetings during the Annual Meeting of this Association and at such other times as necessity may require, subject to the call of the President or on the petition of three Councilors filed with the Executive Director.

Section 3. Publication of Proceedings. The Council shall cause to be published in *The Journal* of this Association a summary of its meetings and actions.

Section 4. Individual Duties of Councilors. Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics.

Section 5. Auditing and Appropriations Committee. An Auditing and Appropriations Committee consisting of three members of the Council shall be appointed by the President, with the consent of the Council, to serve for one year. This Committee shall prescribe the method of accounting and shall audit any and all accounts of this Association. It shall prepare and present annually to the Council a budget providing for the necessary expenses of this Association. Any surplus or

balance of funds for a given year shall revert to the general fund. The President, the President-Elect, the Immediate Past President and the Secretary-Treasurer shall be ex-officio members of such Committee with full voting rights.

Section 6. Salaries and Expenses of Officers and Employees. The salaries of officers and employees of this Association shall be fixed by the Council. The Auditing and Appropriations Committee may allow the payment of necessary traveling and other expenses incurred by officers and Councilors in the discharge of their duties to this Association.

Section 7. Vacancies. Except as otherwise provided by Chapter 6 hereof, the Council shall fill by appointment any vacancy in office occurring in the interval between the Annual Meetings of the House of Delegates. Any such appointee shall serve until the next Annual Meeting of the House of Delegates at which time the office shall be filled in the manner provided for in the Constitution and in these Bylaws.

CHAPTER 8

DELEGATES AND ALTERNATE DELEGATES TO THE AMA

Section 1. Organization. As soon as practicable after their election and installation, the Delegates and Alternate Delegates to the American Medical Association shall nominate from their membership candidates for the chairmanship and vice-chairmanship of the delegation and the Council of this Association shall elect one of such nominees as Chairman and one as Vice-Chairman. The President of this Association will be ex-officio Co-Chairman of the delegation.

Section 2. Duties of the Chairman. He shall act as Co-Chairman with the President of this Association of meetings of the delegation. He shall appoint such committees as may be necessary to assist the work of the delegation. He shall report periodically for the delegation to the Council of this Association.

Section 3. Duties of the Vice-Chairman. He shall perform the duties of the Chairman when the Chairman is absent or otherwise unable to function.

Section 4. Terms of Office. The Chairman and Vice-Chairman shall serve for a period of one year or until their successors are duly elected and qualified.

CHAPTER 9

COMMITTEES

Section 1. Titles of Committees. The standing committees of this Association shall be the following:

1. Committee on Public Relations.
2. Committee on Scientific Work.
3. Committee on Education.
4. Committee on Judicial and Professional Relations.
5. Committee on Membership and Planning.

Other committees of this Association shall be those designated in Sections 4 and 7 of Chapter 4, Section 1 of Chapter 5 and Section 5 of Chapter 7 and such special committees as may be appointed by the President.

Section 2. Appointment. Each year the President, with the approval of the House of Delegates, shall appoint one member for a term of five years to each of the following standing committees: Committee on Public Relations, Committee on Education, Committee on Judicial and Professional Relations, and Committee on Membership and Planning, and shall appoint two members for terms of five years each to the Committee on Scientific Work. The President shall designate the chairman of each standing committee from among its members.

In the event of the death or resignation of a standing committee member or of his inability or refusal to serve, the President, with the approval of the Council, shall appoint a successor to serve until the next Annual Meeting of the House of Delegates, at which time the President, with the approval of the House of Delegates, shall appoint a successor to serve for the balance of the unexpired term of such standing committee member.

The President, the President-Elect and the Immediate Past President shall be ex-officio members, with full voting rights, of each standing committee, of the Auditing and Appropriations Committee, and of each special or other committee appointed by the President.

Section 3. Committee on Public Relations. The Committee on Public Relations shall consist of five appointed members, together with the ex-officio members.

This Committee shall consider especially areas of communications and public relations involving this Association, medicine and public health. This Committee shall, from time to time, consider and evaluate developments, conditions and situations involving medicine and the public health, and may prepare and recommend to the Council public relations programs pertaining thereto. Other committees may seek, and shall be entitled to receive, the counsel and advice of the Committee on Public Relations in regard to public relations aspects of programs, problems and activities involving the other committees of this Association.

In case any subcommittee is appointed, its members may be appointed from the membership of this Association at large, but the chairman of such subcommittee shall be appointed by the President from among the members of the Committee on Public Relations.

Section 4. Committee on Scientific Work. The Committee on Scientific Work shall consist of ten appointed members, together with the ex-officio members. This committee shall have charge of the general arrangements for the Annual Meetings of the Association, including the scientific programs both for general sessions and for such sections as may be authorized by Council, as well as the scientific exhibits.

All receipts from the Annual Meeting shall be turned over to the Secretary-Treasurer of this Association. All expenditures must be authorized in advance by the Auditing and Appropriations Committee.

With the advice of the President and subject to approval by the Council, the Chairman of the Committee on Scientific Work may appoint such subcommittees as he may deem necessary and the President shall appoint a chairman for each subcommittee so appointed.

Section 5. Committee on Education. The Committee on Education shall consist of five appointed members, together with the ex-officio members. This committee shall consider and devise ways and means of (1) extending the educational work of this Association for the benefit of its members, working with the component societies and affiliated district societies, whenever possible; and (2) furthering the education of the general public in health matters and fostering a sane point of view about medical care. Subcommittees may be appointed in the same manner as provided in Section 4 of this chapter.

Section 6. Committee on Judicial and Professional Relations. The Committee on Judicial and Professional Relations shall consist of five appointed members, together with the ex-officio members. It shall have the following duties:

(1) It shall investigate, at the request of the Council, questions and controversies arising under the Constitution or Bylaws of this Association or under the Principles of Medical Ethics of the American Medical Association.

(2) It shall serve as a board of review with respect to proposed amendments to the constitution or bylaws of a component society of this Association and shall submit to the Council for its guidance the Committee's comments and recommendations respecting such proposed amendments.

(3) With the approval of the Council, the Committee may retain counsel to appear as amicus curiae in behalf of this Association in cases which may be pending in the courts where, in the opinion of the Committee, the legal questions involved are of special interest to this Association or its members.

(4) It shall disseminate to members of this Association information relative to the causes of malpractice suits and suggested methods of reducing the incidence thereof.

Section 7. Committee on Membership and Planning. The Committee on Membership and Planning shall consist of five appointed members, together with the ex-officio members.

This Committee shall study and make recommendations to arrive at ways and means of effectuating the stated purposes of this Association and of making organized medicine meaningful and responsive to the needs of the profession and the public.

Subcommittees may be appointed in the same manner as provided in Section 4 of this chapter.

Section 8. Responsibility of Committees. The actions of all standing and special committees shall be subject to the approval of the Council.

CHAPTER 10

COMPONENT SOCIETIES

Section 1. Organization of Societies. Upon application to the House of Delegates, all component societies hereafter organized in this state, which have adopted principles of organization in conformity with the Constitution and Bylaws of this Association, shall receive charters from this Association, provided, however, that their constitutions and bylaws or, in the case of incorporated societies, their articles of incorporation, codes of regulations, code of bylaws or other fundamental bodies of rules of society government, shall have been submitted to the Council and received its approval. All such charters shall be signed by the President and the Secretary-Treasurer.

Section 2. Charters of Societies. The House of Delegates shall have authority and power to suspend or revoke a charter heretofore or hereafter issued to any component society whose actions are in conflict with the Constitution or Bylaws of this Association.

Section 3. Title of a Component Society. The name and title of each component society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of this Association.

Section 4. Custody of Charter. The charter of each component society, as issued by this Association, shall be preserved and shall be kept in the custody of the secretary of such component society at all times.

Section 5. Constitutions of Component Societies. Each unincorporated component society shall have a constitution and bylaws. Each incorporated component society shall have, in addition to articles of incorporation as required by law, a constitution, a code of regulations, a code of bylaws, or other fundamental body of rules for its government similar in content and form to the bylaws of unincorporated component societies. All such constitutions, bylaws, articles of incorporation, codes of regulations and other fundamental bodies of rules shall be in conformity to the Constitution and Bylaws of this Association, and a copy thereof shall be transmitted to the headquarters of this Association for approval and recording. The bylaws of each unincorporated component society, and the code of regulations, code of bylaws, or other fundamental body of rules of each incorporated society shall set forth specifically the duties of the several officers and of its executive body (council or trustees).

Section 6. Changes in Constitution and Bylaws of Component Societies. Whenever a component society shall have made a change or amendment in its constitution, bylaws, articles of incorporation, code of regulations, or other fundamental body of rules for its government, such change or amendment shall be submitted to the Council of this Association for written approval, and such change or amendment shall not become effective until such approval shall have been given.

Section 7. Functions and Duties of Component Societies. Each component society shall have general direction of the business and affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

Section 8. Date Membership Dues are Payable. The membership dues in all component societies shall be due and payable on or before December 1 preceding the calendar year for which such dues are assessed.

Section 9. Official Records of Component Societies. The official copy of the constitution and bylaws of each unincorporated component society, and the official copy of the articles of incorporation, code of regulations, code of bylaws or other fundamental body of rules of each incorporated component society, shall be kept by such component society in a special book provided for that purpose. In such special book shall be entered all amendments which have been approved by the Council of this Association. Such book shall contain the name and address of each component society member who is entitled to membership in this Association; and there shall be recorded in it the date of each member's election, the date of his decease and the date of any resignation or order of suspension or expulsion from the society. It shall be the duty of the society's secretary to preserve this book and hold it available when required for reference.

Section 10. Certification of Delegates of Component Societies. Each component society at its regular annual meeting shall elect delegates to represent it in the House of Delegates of this Association in accordance with these Bylaws, unless other definite procedure for the selection of delegates is provided in its constitution and bylaws, or in its articles of incorporation, code of regulations, code of bylaws, or other fundamental body of rules of society government. The secretary of each component society shall send a list of such delegates and alternates to the Executive Director of this Association at least thirty (30) days before the Annual Meeting of this Association. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions. In the absence of, or the disability or disqualification of a delegate, his duly certified alternate may be seated in his place.

Section 11. Combined Component Societies. The House of Delegates shall have authority to organize the physicians of two or more counties, or parts thereof, into a multi-county society to be designated by hyphenating the names of such counties so as to distinguish them from a district or single county society. Such multi-county societies, when organized and chartered, shall be

entitled to all the privileges and representatives provided herein for component societies.

CHAPTER 11

MEMBERSHIP IN COMPONENT SOCIETIES

Section 1. Qualifications for Membership in a Component Society. To be eligible for active membership or for associate membership in a component society, or other probationary or provisional type of membership of limited duration, a person must possess all of the following qualifications:

(a) He must meet all those requirements for membership in this Association which are enumerated in Section 3 of Chapter 1, hereof, and at the time of making application to the component society shall tender the appropriate Ohio State Medical Association dues and assessments for the current year;

(b) He must not be engaged, nor profess to be engaged, in the practice of sectarian medicine; and

(c) He must be a bona fide resident of, or must conduct the major portion of his practice in, the county in which such component society is located.

Provided, however, that where it is more convenient for a member of a component society to attend the meetings of another component society located in a county adjoining that in which he holds such membership, such member, upon application to, and approval by, both the society in which he holds such membership and the society in such adjoining county, shall be entitled to a transfer of his membership to the latter society; and, provided further, that no person possessing an active membership or an associate membership, or other probationary or provisional type of membership, of limited duration, in one component society may acquire or possess at the same time an active membership, or an associate or other probationary or provisional type of membership of limited duration, in another component society.

As used in this Section 1, "active membership" in a component society means any type of membership having voting and office-holding rights and privileges.

Subject to the provisions of the foregoing paragraphs of this Section 1, each component society shall be the sole judge of the qualifications necessary for any and all classes of membership in such society.

Section 2. Roster of Members. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each meeting of the society to the Councilor of his district and to the Executive Director of this Association.

Section 3. Change of Residence. When a member in good standing in a component society moves to another county in this state, he shall be given upon request a written certificate of those facts by the secretary of his society, without cost, for transmittal to the secretary of the component society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he moves, such member shall be considered to be in good standing in the component society from which he was certified and in this Association to the end of the period for which his dues have been paid.

Section 4. Disciplinary Procedure. Disciplinary action may be taken by a component society against a member thereof only upon written charges signed by a member or members of such society and filed with the society's secretary. As soon as possible, and in any event not later than ten (10) days after such filing, the secretary shall serve upon the accused member a true copy of such charges and shall also furnish to the Councilor for the district a copy thereof. Within thirty (30) days thereafter, the society shall fix a time and place for a hearing on said charges and the secretary shall serve prompt written notice of such time and place upon the accused member and shall also furnish to the Councilor for the district a copy of such notice. Such hearing shall be held as soon as practicable but in no event sooner than twenty (20) days, or later than sixty (60) days, after the date of service of such notice upon the accused member. Service upon the accused of a copy of such charges or of such written notice, or both, may be made by delivering the same personally to the accused, or by sending the same by registered mail and also by regular mail addressed to the accused at his usual place of residence.

At the hearing upon such charges the accused shall be afforded full opportunity to be heard in his own defense, to be represented by legal counsel of his own choosing, to cross-examine the witnesses who testify against him, and to examine witnesses and offer evidence in his own behalf. The hearing shall be held and conducted in such a manner as to ascertain all the facts fairly to the accused and the society without requiring compliance with those formal or technical rules and requirements which ordinarily pertain to judicial proceedings. Failure of the accused to appear or be represented at the hearing may be considered prima facie evidence of the truth of the charges.

A record shall be made of such hearing, and at the request of either the accused member or the component society, the society's secretary shall cause a transcript to be made of the proceedings, evidence and findings in connection with such hearing without charge to the accused member. If the findings shall include, or be followed by, an order or decree of the component society suspending or expelling the accused member from the society, the execution or enforcement of such order or decree shall be stayed until the expiration of the time allowed by Section 5 hereof for the perfecting of an appeal to the OSMA, and thereafter shall be stayed during the pendency of any appeal that may have been timely filed and perfected. Prompt written notice of the findings and order or decree shall be served by the secretary upon the accused member together with a copy of such findings and order or decree.

Section 5. Appeals. Any member who has been censured by his component society, or who has been suspended or expelled from membership therein, shall have the right to appeal to the Council of this Association from the order of censure, suspension or expulsion; and the Council shall have jurisdiction to hear and determine such appeal, and to affirm, modify or reverse the order of the component society. Any such appeal shall be on questions of law and procedure only, and not on questions of fact. Such appeal must be filed with the Council within twenty (20) days after the date of the service upon the accused member of the component society's order from which the appeal is taken; with such appeal the appellant shall file proof that a copy of such appeal has been mailed to, or otherwise served upon, the president or secretary of the component society from whose order the appeal is taken.

As soon as practicable, and within forty (40) days after the filing of such appeal, or within such additional time as may be allowed by the Council, the component

society shall file with the Council a record of the society's disciplinary proceedings against the appellant, including the original papers, documents, resolutions and minutes, or copies thereof, relating thereto, and including a transcript of the proceedings, evidence and findings in connection with its hearing on the charges against the appellant. With such record there shall be filed a certificate signed by the president or secretary of such society certifying that such record constitutes a complete, true and correct record of all the disciplinary proceedings before such society, and further certifying that a true and correct copy of such record, and written notice of the filing of such record with the Council, have been mailed to, or otherwise served upon, the appellant. If the component society shall fail or refuse to file such record within the said forty (40) days or within such additional time as may be allowed by the Council, the Council may enter an order sustaining such appeal and reversing the order or decree of the component society.

Following the filing of the record by the society the Council shall fix the time for the filing of briefs by the accused and the society and shall set a date for the hearing of the appeal before the Council, and the Executive Director shall give prompt notice thereof to each party and to each party's counsel.

The appeal shall be heard, considered and determined by the Council solely upon the record filed by the society with the Council and the briefs and oral arguments of the parties or their counsel: and the decision of the Council shall be final and binding on both the accused member and the society.

Section 6. Effect of Failure of a Component Society to take Requested Disciplinary Action. In the event that a component society shall fail or refuse to take prompt disciplinary action against one of its members after being requested in writing by the Council of this Association to do so, the Council of this Association may cause such disciplinary action to be instituted and prosecuted; and in any such disciplinary action so instituted the procedure prescribed by Section 7 of Chapter 1 of these Bylaws shall govern; and at the conclusion of the hearing by the Council it may enter such order of (a) dismissal of the charges, or (b) censure of the accused member, or (c) suspension from the society, or (d) expulsion from the society as the evidence adduced at such hearing shall warrant. The decision of the Council shall be final and shall be binding on both the accused member and the component society.

Section 7. Exculpatory Provision. No person against whom disciplinary action is instituted pursuant to the provisions of this Chapter 1 shall have any claim or cause of action against this Association or a component society or against any officer, Councilor or member of such Association or society, by reason of the institution, prosecution or disposition of such charges or the hearing or consideration thereof.

Section 8. Effect of Expiration, Revocation or Termination of a Certificate. Membership in a component society of a member of such society whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be canceled automatically as of the effective date of such expiration, revocation, or termination.

Section 9. Effect of Failure to Maintain Membership in the Ohio State Medical Association. Membership in a component society of a member of such society who has failed to acquire and maintain membership in this Association shall terminate automatically.

CHAPTER 12

ETHICAL PRINCIPLES

The ethical principles governing the members of the American Medical Association shall govern members of this Association.

CHAPTER 13

RULES OF PROCEDURE

The deliberations of this Association shall be conducted in accordance with parliamentary usage as prescribed in the Sturgis' Standard Code of Parliamentary Procedure, by Alice Sturgis.

CHAPTER 14

REFERENDUM

Within sixty (60) days after a general referendum has been ordered either by the (1) House of Delegates, or (2) upon the petition of at least thirty (30) component societies as prescribed in Article X of the Constitution, the Executive Director shall prepare and have printed and mailed by first-class mail to each Active Member of this Association an official circular setting forth the following:

(a) A resume of the provisions in this Constitution and Bylaws applying to a general referendum;

(b) An announcement by the President as to the time set by him for closing the polls which shall be not less than fifteen (15) days nor more than thirty (30) days after the mailing of circulars and ballots;

(c) The resolution, motion or action submitted to referendum;

(d) A statement of not more than 200 words prepared by the proposer or proposers of the resolution, motion or action giving arguments in its favor;

(e) A statement of not more than 200 words giving arguments in opposition prepared by one or more members appointed by the President from among those opposed to the resolution, motion or action.

Enclosed with the circular shall be an official reply envelope and a ballot labeled with the official seal of this Association. On the ballot the resolution, motion or action shall be printed and below it shall be spaces for the indication of "yes" or "no" by making a cross mark. The reply envelope shall be addressed to a special committee of three tellers appointed by the President and it shall carry return first-class postage or the equivalent thereof under the postal regulations.

To be counted by the tellers a ballot shall meet the following requirements:

(a) Either "yes" or "no" must be clearly indicated with a cross mark;

ON THE OMPAC FRONT

Change? Yes! But What Kind of a World Do You Want?

"Shall PaMPAC Continue?", asks Dr. William B. West, chairman of the Pennsylvania counterpart of the Ohio Medical Political Action Committee, in an article in *Pennsylvania Medicine.*

Dr. West's observations and admonitions are just as pertinent to Ohio and Ohio physicians as they are to the Keystone State and its doctors. Here's what he wrote, in part:

"Perhaps it is because some of us who are so intimately involved and feel so keenly the need for this organization and its work that we ask ourselves this question in moments of despair and disillusionment. Many of us feel that less than half of the membership of PMS is a poor representation and surely not a mandate for positive action —this particularly when our profession is being battered from all sides by socialists, labor leaders and just plain demagogues, all with the same idea in mind — complete socialization of American Medicine.

Justice Holmes once said, "Behind every scheme to make the world over lies the question, 'What kind of world do you want?'" The members of our profession need not ask this question. We have been adequately advised by the Reuthers, by the Cohens and many others that satisfaction will never be appeased with less than complete socialism in medicine. ★★★

"When the truth is so difficult to come by in government, what can a single voice crying in the wilderness accomplish? The answer is "nothing." More than ever, it is necessary to have a strong, active organization to speak with some authority when elections roll around if anything worthwhile is to be gained in our appeals and requests. ★★★

"With the present Administration fighting inflation, we have too many congressmen who fail to vote their consciences. They now vote to increase spending by millions of dollars over and above that called for in the budget, thereby feeding the fires of inflation, solely to guarantee their vote-getting powers. We must have more elected officers who vote their better judgment rather than vote political expediencies. Who is in a better position to try and accomplish this than your political action committee? ★★★

"It would appear that in spite of admonishments from many in high places in the Federal and State Governments suggesting that all men of medicine should become very active in politics, a large number of our profession will not even join an organization willing to work for their interests. Too many are willing to live day-by-day and let the future bring what it may. What it brings may not be good, however.

"To those who are not members of PaMPAC, I would suggest that we still need your help and, in so doing, you might help yourselves immeasurably in the near future."

Interesting Figures Given on U. S. Accident Death Rate

Accidents caused an estimated 116,000 deaths in 1969, or approximately 1,000 more than in 1968. The provisional death rate in the year just ended was virtually the same as in 1968, when the figure was 57.5 per 100,000 population.

An increase in the death toll from motor vehicle accidents was in large part responsible for the rise in the loss of life from accidents during 1969. Motor vehicle fatalities increased by somewhat over 1,000 to 56,500 in 1969, a new high. Preliminary data indicate, however, that motor vehicle deaths rose less than the volume of travel. This produced a slightly lower death rate per 100 million vehicle miles traveled than the 5.5 recorded in 1968—the third successive decline in this annual figure.

Public accidents other than those involving motor vehicles also figured prominently in the rise in the death toll from all accidents combined, with an increase to 21,500—about 1,000 over the figure for the previous year.

The number of job-related fatalities in 1969 was approximately 14,500, or about the same as in the previous year; about 3,300 of these deaths are included in the estimate of 56,500 motor vehicle fatalities mentioned above. The toll from injuries in and about the home declined to about 27,000, or by approximately 1,500 from the 1968 total.

Statisticians point out that effective in 1968 a revision was made in the official method of classification of the *International List of Causes of Death* (Eighth Revision). The figures for that year and 1969 are not strictly comparable with those for earlier years. It is believed that the 1969 and 1968 estimated figures are somewhat higher than they will be when the official totals are published by the National Center for Health Statistics.—Metropolitan Life Insurance Company

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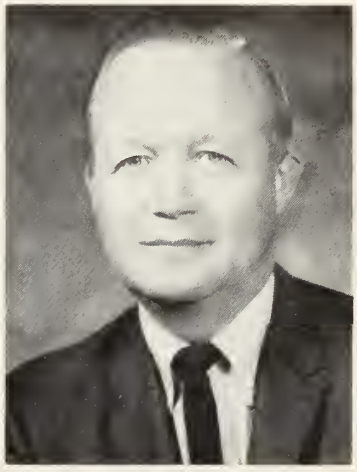
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A MESSAGE FROM

Your OSMA President



THIS MESSAGE IS PRESENTED with a good measure of pride and is promoted by two highlights in our organization's activities. The first has to do with the almost overwhelming response on the part of the membership to the Opinion Survey, and the second is a quick look into the drama that sometimes unfolds in securing top speakers for the OSMA Annual Meeting.

* * *

In regard to the Opinion Survey, the response has been exceptional and most gratifying. Approximately a 52 percent return has been recorded as of February 11. Our public relations people tell us that this is a much greater return than would ordinarily be expected from such a large mailing. The entire OSMA membership numbering nearly 10,000 received the questionnaire.

Personally, and on behalf of the Association, I wish to thank each of you for taking the time to complete the questionnaire. The response tells me that our members do care.

With over 5,000 returns, obviously time is required in compiling and interpreting the response, even though computers will help in tabulating the results.

I assure you that your officers will be responsive to your thoughts, suggestions, and criticisms.

* * *

My second thought regards a behind-the-scenes view of a drama that I trust will prove rewarding as well as interesting.

You all remember last summer's controversial issue over the appointment of Dr. John Knowles to high office in the U. S. Department of Health, Education and Welfare, and the subsequent appointment of Dr. Roger O. Egeberg as Assistant Secretary for Health and Scientific Affairs. As I'm sure you also know, Dr. Egeberg has met with more than ordinary success in his new office and has proved himself a physician and executive of great stature.

It was my privilege and pleasure to hear Dr. Egeberg speak at the New York meeting of the American Medical Association. I immediately decided that more physicians of Ohio should have an opportunity to hear this man and to listen to his message, especially since he is a former Ohioan.

Knowing that Dr. Egeberg was in tremendous demand as a speaker and that he was working and traveling on a superhuman schedule, I determined to make a bid for his presence as guest speaker at the OSMA Annual Meeting in Columbus, May 11-15. It was a dramatic experience, requiring letters, telephone calls, and personal persuasion before a solid commitment for his appearance could be obtained. I "bird-dogged" him from New York to Cincinnati, from Cincinnati to Denver, from Denver to Detroit, and finally to Cleveland.

The end result is that he has agreed to speak at the Annual Meeting and physicians are urged to hear him beginning at 2:00 p.m. on Wednesday, May 13 in the Main Auditorium of the Veterans Memorial Building in Columbus.

After hearing him several times, I am convinced that he will have a message of special interest to the physicians of Ohio.

Robert N. Smith, M.D.

Robert N. Smith, M.D., President
The Ohio State Medical Association

Continuing Education Opportunities for Physicians in Ohio

Periodic Courses

Visiting Surgical Faculty Monthly Seminars — Mercy Hospital, Springfield; 1½ hours a day, once a week, September 11 through May 14, 1970; for specialists and nonspecialists.

Visiting Medical Faculty Weekly Seminars — Mercy Hospital, Springfield; 1½ hours, one day a week through May 30, 1970; for specialists and nonspecialists.

Tumor Conference — Youngstown Hospital Association; two hours a day, once a week, through June, 1970; for specialists and nonspecialists.

Electrocardiography Review — Youngstown Hospital Association; 1½ hours a day, two days a month; through June, 1970; for specialists.

Psychiatric Treatment Methods — Veterans Administration Hospital, Brecksville; three hours a day, one day a month, October 8 through May 13, 1970; for specialists and nonspecialists.

March

Medical Seminars — The Youngstown Hospital Association, March 9, "Subacute Hepatitis," Drs. D. B. Brown and P. C. Patel; March 23, "Lipoprotein Abnormalities and Coronary Atherosclerosis."

Clinical Problems in Internal Medicine — Sponsored by the American College of Physicians at the Cleveland Clinic, 2020 East 93rd Street, Cleveland, March 16-20. Details through the ACP office, 4200 Pine Street, Philadelphia, Pa. 19104.

Review Day in General Medicine—Ohio State University College of Medicine, Columbus, March 18.

Annual Cancer Symposium—Akron City Hospital, 525 E. Market Street, Akron, March 18-19; for specialists and nonspecialists.

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown—**Malignant Hypertension,** Alvin Shapiro, M.D., University of Pittsburgh, March 19.

Feed-Back Mechanisms in Endocrine Disease — Trumbull Memorial Hospital, Warren, March 24.

Diabetes Mellitus—Third Annual Postgraduate Seminar presented by Greater Akron Area Diabetes Association, 430 Grant St., Akron 44311; program March 25 at Downtown Holiday Inn, 200 E. Exchange St., Akron.

Practical Management of Infectious Diseases, 1970—Ohio State University College of Medicine; for specialists and nonspecialists; March 25.

Medical Progress and Its Relationship to Dentistry—The Cleveland Clinic Educational Foundation, March 25-26.

Multiple Sclerosis and Related Demyelinating Diseases—Ohio State University College of Medicine, Columbus, March 26; for specialists and nonspecialists.

April

Third Annual Cancer Symposium—Ohio State University College of Medicine, Columbus, April 1; for specialists and nonspecialists.

Advances in Infectious Disease—Cleveland Clinic Educational Foundation, April 1-2.

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown—**Pacemakers** (in General), James Leonard, M.D., University of Pittsburgh, April 2; **Chronic Pancreatitis,** Bertram Fleshler, M.D., Case Western Reserve University, April 23.

Recent Advances in Human Genetics — Youngstown Hospital Association, South Unit, Thursday, April 2, 8:00 a.m. Guest Professor, Cecil B. Jacobson, M.D., associate professor of obstetrics and gynecology, George Washington University.

Sports Medicine—Cleveland Clinic Educational Foundation, April 6-7.

A Day of Cardiology—Current Problems in Clinical Management — Ohio State University College of Medicine, Columbus, April 8.

New Directions in Coronary Care for the 1970's—American College of Cardiology, at Good Samaritan Hospital, 1425 W. Fairview Ave., Dayton, April 8-9.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Visiting Professor of Surgery Series: St. Elizabeth Hospital Youngstown—**Portal Hypertension,** Bernard Fisher, M.D., University of Pittsburgh, April 9; **Changing Trends in the Treatment of Breast Cancer; Surgical Management of Acute and Chronic Pancreatitis,** Robert E. Hermann, M.D., Cleveland Clinic Foundation, April 23.

One Week Physician Course—Nuclear Medicine — April 13-18; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

Athletic Injuries—Marvin McClellan, M.D., Cincinnati; Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, April 14, 8:15 p.m.

22nd Annual Freedman Lectures in Diagnostic Radiology — University of Cincinnati College of Medicine, April 18-19; Lectures by Dr. Jerome Shapiro, director, Department of Radiology, Boston City Hospital, and professor and chairman of radiology at Boston University Medical School; contact Dr. Benjamin Felson, Department of Radiology, Cincinnati General Hospital, 234 Goodman St., Cincinnati 45229.

Investigation of Thyroid Disease—Trumbull Memorial Hospital, Warren, April 22.

Postgraduate Course in Pathology—Cleveland Clinic Educational Foundation, 2020 E. 93rd Street, April 22-23; for specialists and nonspecialists.

Annual Laboratory Animal Medicine Conference—University of Cincinnati College of Medicine, April 25 at Christ Hospital, Cincinnati.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; April 13 — "Mechanisms of Action of Antibiotics," Drs. G. Butcher and N. Pappas; April 27 — "Bronchiectasis — A Review," Drs. H. Bennett and D. Roble.

May

Fifth Annual Conference on the Newborn — Ohio State University College of Medicine, 410 West 10th Avenue, Columbus 43210; May 6; for physicians and nurses.

Progress in Cardiovascular Diseases — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; for specialists and nonspecialists; May 6-7.

Radiology — Youngstown Hospital Association, South Unit, Thursday, May 7, 8:00 a.m.; Guest Professor for the John Heberding Lecture, Milton Elkins, M.D., professor and chairman of radiology at Albert Einstein College of Medicine, New York.

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown —**Tall Girl Syndrome,** T. S. Danowski, M.D., University of Pittsburgh, May 7; **Glomerulonephritis,** Alvin Shapiro, M.D., University of Pittsburgh, May 21; **Infectious Hepatitis,** Edward Rotheram, M.D., University of Pittsburgh, May 28.

Second Annual Seminar — Trauma of the Head and Neck — University of Cincinnati College of Medicine, CONMED, Eden and Bethesda Avenues, Cincinnati 54219; May 7-9; specialists and nonspecialists.

One Week Physician Course—Nuclear Medicine — May 11-16; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

1970 Annual Meeting, Ohio State Medical Association, Columbus, May 11-15; hours of postgraduate short courses; general session, specialty section and specialty society programs.

Prevention of Cancer—St. Elizabeth Hospital, Youngstown, May 14, Emmanuel Farber, M.D., Ph.D., chairman, Department of Pathology, University of Pittsburgh.

Radiology—Annual Meeting of the Ohio State Radiological Society, May 15-17 at the Cleveland-Sheraton Hotel, Cleveland; convention chairman, Theodore J. Castele, M.D., Lutheran Hospital, 2609 Franklin Blvd., Cleveland 44113.

Kidney Disease Symposium — University of Cincinnati Medical Center, May 20.

Advances in Dermatology — Cleveland Clinic Educational Foundation, May 21-22; for specialists and nonspecialists.

Tuberculosis and Respiratory Diseases — Cleveland-Sheraton Hotel, Cleveland, May 24-27; sponsored by the American Thoracic Society and National Tuberculosis and Respiratory Disease Association, 1740 Broadway, New York 10019.

Refresher Course in Diagnostic Radiology — University of Cincinnati Medical Center, May 24-29.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; May 11 — "Virilism," Drs. C. McGowen and N. Suanprasert; May 25 — "Hypertension in Primary Renal Disease," Drs. R. Bacani and S. Young.

June

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown —**Pericarditis,** James Leonard, M.D., University of Pittsburgh, June 4; **GI Bleeding, Etiology Undetermined; Malabsorption,** George Gabuzda, M.D., Case Western Reserve University, June 18.

Otologic Surgery, Using Live Color Television — University of Cincinnati Medical Center, June 5-9.

One Week Physician Course—Nuclear Medicine — June 8-13; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; June 8 — "Fungal Infections of the Skin," Drs. K. Lloyd and B. Thimmappa; June 22 — "Diabetic Neuropathy," Drs. L. Green and W. Tsang.

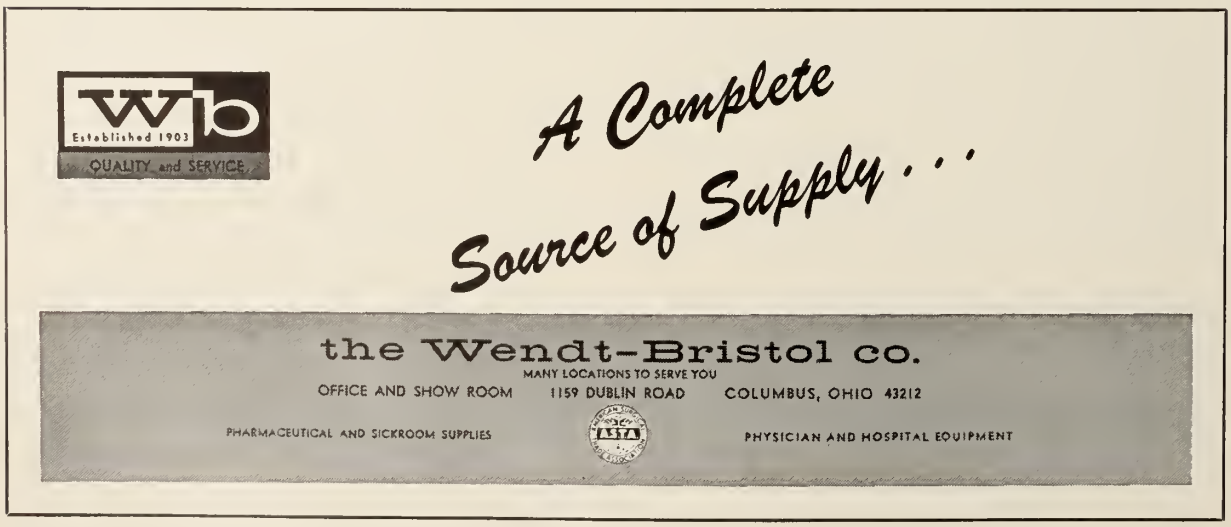
Second Annual Urologic Outing on Controversies in Urology — Sponsored by The Ohio State University Division of Urology at Burr Oak State Park, Ohio, on June 29, 30, and July 1. Modern, air-conditioned facilities. Please contact Program Director Chester C. Winter, M.D., Division of Urology, Ohio State University Medical Center, 410 W. 10th Avenue, Columbus 43210.

Medical Library School Seeks Masters Candidates

In recognition of the demand for trained personnel, a training program in medical librarianship and communication in the health sciences has been initiated by the School of Library Science of Case Western Reserve University with support from the U.S. Public Health Service through the Extramural Program of the National Library of Medicine. This program provides an integrated sequence of specialized courses in medical librarianship and communication within the School's one-year Master of Science in Library Science curriculum. Graduates are eligible for certification by the Medical Library Association.

Ten stipends of $2,400, plus dependency allowance and full payment of fees, are available for 1970-71 to selected applicants of excellence and promise, but enrollment in the program is not limited to recipients of stipends. For other financial aid, see the Library School catalog. Ample opportunity for part-time employment is available in the many libraries in the University Circle area and throughout Greater Cleveland.

Persons interested in more information should write: Professor Alan M. Rees, Director, Training Program in Medical Librarianship, 10831 Magnolia Drive, Cleveland, Ohio 44106.





Investment Prognosis

By Frank Van Holte, Columbus

THE DISCOVERY OF OIL on the north slope of Alaska has certainly been confirmed as one of the most important economic events in recent history. About 50 companies bid over $900 million for leases on approximately 450,000 acres, and the oil companies bid particularly high prices for tracts in the Prudhoe Bay area. Oil experts estimate that this field has an estimated five to ten **billion** barrels of recoverable reserves. The only other U.S. oil field to come close to this area is the East Texas field discovered in 1930 with five billion barrels.

Acknowledging that it will take several years to develop this area sufficiently to produce profits, an investment in companies participating in the North Slope should prove rewarding to investors over the long term. Many of the large oil companies have important holdings in this area. The list includes Atlantic Richfield, Getty Oil, Mobil Oil, Phillips Petroleum, Standard Oil of California, Standard Oil of Indiana, and Standard Oil of Ohio. Sohio acquired its interest through its merger with the United States Subsidiary of British Petroleum. Mobil Oil appears to be a particularly attractive investment not only because it has a large position on the North Slope, but it also has an excellent domestic operation.

Incidentally, I don't think we should envy the oil prospectors working on the North Slope. We have had a severe winter in Ohio, but consider the climate on the Slope. In winter the average mean temperature at Point Barrow is about 30 degrees below zero, with the Tundra being frozen to a depth of 500 feet or more. In summer the temperature rises to a high of 40° above and this blast of warm air brings in swarms of giant mosquitos and you can bet that that these mosquitos will sharpen their drills on the oil drillers. I imagine the oil company employees will not be bothered with sightseers. By the way, Valdez will become an important city in Alaska. This ice-free port will become the southern terminus of an 800 mile pipeline from the North Slope.

I heard a banker say recently "This isn't the Age of Aquarius—it's the Age of Credit Cards."

I look for a change in the level of interest rates on tax-exempt bonds in the wake of the Tax Reform Act of 1969. Many of the traditional buyers of these bonds will be back in the market, and this return will have a tendency to lower the yields on tax-exempts scheduled in the coming months. Thus, it seems to me that the individual buyer should take advantage of the 6 to 7¼ percent yields now available before they start to slide. It is apparent that capital gains are almost inevitable and this coupled with the high current return makes these tax-free bonds extremely attractive if you have the savings dollars available.

It has been said that inflation, particularly sustained inflation, is pervasive, appearing in many guises. This causes us to blame "the other guy" when we attempt to identify the causes. Haven't you heard the banks being blamed for inflation because of their high interest rates? Or, the unions being blamed for their demands for higher and higher wages? How about the "middlemen" being blamed for the high prices of meats and groceries? Thus the list of causes goes on and on, varied by our own personal opinions and experiences. But most economists believe that inflation has one essential cause; a monetary policy that has pushed up the quantity of money more swiftly than the production of goods and services. They believe that this is the true cause notwithstanding the thousand faces or guises. But I don't believe housewives will readily agree with this opinion. It is difficult to associate the supply of money with the price of eggs. And so, the many faces appear all around us and this makes it extremely difficult to accept any method of curbing inflation that we don't understand.

Investors are apparently finding it difficult to immunize themselves from the concern and gloom that prevails in the market today. They keep hoping that the investment climate will improve and in the meantime, they keep stuffing the cookie jar. The facts are that the decline in the market has created investment opportunities that occur once or twice every five or six years.

This monthly feature is written for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Unique Dial-a-Tape Service Installed for Toledo Area Doctors and Nurses



Dial-a-tape information service for doctors and nurses was launched in Toledo during January by the Northwestern Ohio Regional Medical Program. On hand to make the first calls were (from left) Dr. C. Robert Tittle, program coordinator for NWORMP; Dr. Glidden Brooks, president of the Medical College of Ohio at Toledo, and Dr. Peter Overstreet, retiring president of the Academy of Medicine of Toledo and Lucas County. Walls of the dial-a-tape nerve center are lined with recorded lectures on 325 subjects for doctors and 130 for nurses.

Dial-a-Tape Data Available in 20 Northwestern Counties

A dial-a-tape information service, which places up-to-date medical information within reach of a physician's or nurse's telephone, was inaugurated here in January at the offices of the Academy of Medicine of Toledo and Lucas County.

Established by the Northwestern Ohio Regional Medical Program and funded by the Federal government, sponsors point out that this is the first service of its kind in Ohio.

The service provides "quickie lectures" on 325 subjects for 1,300 doctors in 20 counties plus 130 topics for 6,000 registered nurses.

Dr. Glidden Brooks, president of the Medical College of Ohio at Toledo, and Dr. Peter Overstreet, retiring Academy president, placed the first calls at a special kickoff ceremony.

The service, which Toledo officers further point out, is first in the United States for a metropolitan area, covers Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams and Wood Counties. A similar service is offered, but only

on a state-wide basis, to doctors in Wisconsin, Missouri, New Mexico, Minnesota and North Dakota.

The calls are toll free.

The service works like this:

A doctor dials a number furnished to him by the regional medical program office. A librarian answers. The doctor asks for the subject in which he is interested. (All topics are listed by subject and number in a directory furnished by NWORMP.) The librarian finds the tape and inserts it into a slot over the telephone. The doctor listens and makes notes.

The project is expected to be a giant step forward in an effort to help busy doctors and other health professionals "keep up" on rapidly changing subjects in the medical field, according to Dr. C. Robert Tittle, NWORMP program coordinator.

The directory includes subjects ranging from allergies, infections and nervous system disorders to topics for psychiatrists.

Based on experiences in Wisconsin, Dr. Tittle predicted that Northwestern Ohio doctors will use the taped lectures, which range from one to 12 minutes in length, for general education, helping solve specific patient problems and emergency situations.

Other Activities of County Societies

GUERNSEY

Guernsey County Medical Society, meeting this week (early January) at the Holiday Inn, approved a program being introduced the latter part of February to immunize all children in Cambridge and Guernsey County from the age of two through the age of 12 against German Measles.

An epidemic of major proportion is expected this spring or early in 1971. . . .

The State Health Department will furnish the vaccine to immunize all school children from the first through the fifth grade. The Guernsey County Health Department has allotted $1,500 toward the purchase of the 3,000 doses estimated to be required to immunize the other children.

Since immunizing doses cost $1.50 each, an appeal has been made to both the city and the county boards of education to furnish the additional money required. They have expressed a willingness to participate but apparently there may be no legal way for them to do this.

Parents who can afford to do so will be requested to donate $1.50 per child to cover the cost of the immunization dose. A drug company has agreed to supply the health department with 3,000 immunization doses which have been and are still in short supply.

Instructional films on Sciatica and the intervertebral disk and surgical approach to the ankle joint and foot were then shown.

New officers of the society are: President, M. C. McCuskey, M.D.; vice-president, J. D. Knapp, M.D.; and secretary-treasurer, Quentin Knauer, M.D. Committees were appointed.

The committee on physician recruitment, headed by Drs. William Denny and D. O. Snyder, reported that during the past six weeks eight physicians were contacted in regard to locating in Guernsey County with seven negative responses and one expressing a moderate degree of interest.

—*Jeffersonian,* Cambridge

LORAIN

An above average attendance showed at the November 11th meeting of Lorain County Med-

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ical Society, to hear Marshall W. Dietrich from National Aeronautics and Space Administration's Lewis Research Center in Cleveland. A research project engineer, Mr. Dietrich's topic was "First Lunar Landing Mission," which he illustrated with colored films taken on the moon's surface during the Apollo 11 Mission. He concluded his presentation with remarks on the medical aspects of the project, followed by questions from the audience.

During the business meeting which preceded the program, president Maynard J. Brucker, called upon Delbert L. Fischer, chairman of the Nominating Committee to present the Slate of Officers for 1970.

Robert P. McFarland, M.D., of Oberlin, was installed as the new president of Lorain County Medical Society at the Annual Meeting in Oberlin Inn, on the evening of December 9. Dr. McFarland, a general practitioner, received the gavel of office from the outgoing president, Maynard J. Brucker, M.D., of Amherst. The ceremony was part of the installation of officers in their new terms of office, which will be effective as of January 1, 1970.

The 1969 President's Report, by Dr. Brucker, included commendation to several committee chairmen and members for their activities during the past year, and also to members of Council whose terms of office had expired, for their support during his tenure of office.

Secretary-Treasurer N. V. Leano reported on the financial and membership aspects of the Society.

William R. Schultz, M.D., Councilor of the Eleventh District, presented tokens of appreciation to outgoing officers in the form of seals and ribbons of office.

Following the business meeting, members of the Woman's Auxiliary sponsored a Benefit Auction of various forms of art-work, made and donated by members and wives. Proceeds from the sale will be allocated to the Scholarship Fund of Lorain County Medical Foundation to assist students studying towards careers in medicine, nursing and similarly related fields.

STARK

Dr. Frank O. Goodnough, of Massillon, was installed as President of the Stark County Medical Society on December 11 in the Garden Room of Mergus Restaurant as the organization conducted the 66th Annual Meeting.

Dr. Goodnough is a member of the Association of American Physicians and Surgeons, and the Ohio State and American Medical Associations. He is Past President of the Massillon City Hospital medical staff, a Past President and member of the Board of the Massillon YMCA, and a member of Rotary.

Also selected at this Annual Meeting was President-Elect for 1970 Dr. E. E. Grable, of Canton.

Dr. H. H. Clapper of Canton was elected Secretary-Treasurer. Four new members of the Board of Censors were elected to join Dr. Murray Scott and Dr. William Simmons. They are Dr. A. S. Ahbel and Dr. Joseph P. Yut of Canton, Dr. Raymond C. McMahon of Massillon, and Dr. L. N. Mitchell of Alliance.

Selected as Stark County Delegates to the Ohio State Medical Association were Dr. W. B. Epps of Massillon, Dr. William D. Baker of Alliance. They join Dr. Mark Herbst and Dr. William White in representing the County. Alternate delegates are Dr. Christopher King of Alliance and Dr. E. Joel Davis of East Canton.



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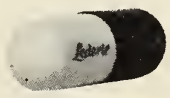
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mixed bacterial infection
osteomyelitis
otitis
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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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Obituaries

Salvador Morales Adriano, M.D., South Fort Mitchell, Ky.; Faculty of Medicine of the University of Santo Tomas, the Philippines, 1949; aged 45; died in November, 1969; member of the Ohio State Medical Association, the American Medical Association, International Academy of Pathology, American Association of Pathologists and Bacteriologists, College of American Pathologists; diplomate of the American Board of Pathology; practicing physician for a number of years in Cincinnati where he specialized in pathology; chief deputy coroner for Hamilton County; associate professor of pathology at the University of Cincinnati; survived by his widow, a son, two daughters, his mother, and a brother.

Tibor Agoston, M.D., Columbus; medical degree from the Royal University of Budapest, 1928; aged 65; died January 26; member of the Ohio State Medical Association; American Medical Association, American Psychoanalytic Association, and the American Psychiatric Association; native of Hungary; on the staff of the Columbus State Hospital since 1950 and director of its Psychotherapy Department; author of the recently published book, *Insight Therapy;* survived by his widow, two daughters; also a sister in Hungary.

John Eugene Aten, M.D., Canton; University of Michigan School of Medicine, 1921; aged 73; died January 15; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; devoted virtually all of his professional career to practice in the Canton area; member of the United Presbyterian Church and several Masonic bodies; survived by his widow, a daughter, two sons, and a brother.

Earl William Burgner, M.D., Akron; Marquette University School of Medicine, 1931; aged 69; died January 11; member of the Ohio State Medical Association; former member of the American Medical Association; member of the Ohio Academy of General Practice, also former secretary and member of the board of OAGP; past president of the Summit County Medical Society; practitioner in the Akron area for more than 40 years; former star athlete and named to the Summit County Hall of Fame; former board member of the Oesterlen Home for Children in Springfield; member of several Masonic bodies; veteran of both World Wars I and II and attained rank of lieutenant colonel in the latter; survived by his widow, two daughters, a son, and a sister.

Harold William Gillen, M.D., Wellston; Indiana University School of Medicine, 1924; aged 76; died January 23; member of the Ohio State Medical Association and the American Medical Association; practitioner in the Wellston area of Jackson County for some 40 years; president of



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the city board of health for more than 15 years; served in the Navy Medical Corps during the 1920's; survived by his widow, a daughter, and two brothers.

Adolphus Cosmo Marinelli, M.D., Youngstown; Ohio State University College of Medicine, 1924; aged 72; died January 17; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; resident of Youngstown for most of his life and a practitioner there since 1926; served in the Medical Corps during World War II with rank of lieutenant colonel; also a veteran of World War I; survived by his widow, two daughters, five brothers, and four sisters.

James Dennis Merida, M.D., Cleveland; Meharry Medical College, 1918; aged 86; died December 31; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the American Geriatrics Society; member of the National Medical Association and served on its board of trustees; named physician of the year by the NMA in 1958; past president of the Buckeye Medical, Dental and Pharmaceutical Association; practitioner of long standing in Cleveland; member of the Masonic Lodge, trustee in the Methodist Church, member of the Cleveland Business League, Metropolitan Club and other professional and civic organizations; survived by his widow, three daughters, and three sisters.

Leon Frank Moldavsky, M.D., Akron; University of Illinois College of Medicine, 1938; aged 58; died January 4; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Abdominal Surgeons; Fellow of the American College of Obstetricians and Gynecologists, the International College of Surgeons, and the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology; practitioner of long standing in Akron, specializing in obstetrics and gynecology; served in the Army Medical Corps during world War II; member of the Temple, B'nai B'rith, the American Legion, and the Jewish War Veterans; survived by his parents and a sister.

Philip John Reel, M.D., Columbus; Ohio State University College of Medicine, 1915; aged 80; died January 25; member of the Ohio State Medical Association, the American Medical Association, and the Central Association of Obstetricians and Gynecologists; Fellow of the American College of Obstetricians and Gynecologists, and

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the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology; practitioner of long standing in Columbus; professor and recently professor emeritus of obstetrics and gynecology at Ohio State University; veteran of World War I; survived by two daughters.

McKinley Alfred Schlott, M.D., Alliance; Ohio State University College of Medicine, 1926; aged 79; died January 22; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; practitioner in Alliance from 1926 to his retirement about a year ago; member of the Chamber of Commerce, the United Methodist Church, and several Masonic bodies; survived by his widow.

Helmut Heinz M. Schories, M.D., Cleveland; medical degree from the University of Erlangen, Germany, 1947; aged 66; died January 14; member of the Ohio State Medical Association and the American Medical Association; recently a member of the staff of the Cleveland Psychiatric Institute; formerly director of the Moundbuilders Guidance Clinic in Newark, and previously on the resident staff of Columbus State Hospital; survived by his widow and two children.

Ivan Campbell Smith, M.D., Canfield; Ohio State University College of Medicine, 1925; aged 67; died December 31; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Physical Medicine and Rehabilitation; past president of the Mahoning County Medical Society; practitioner in the Canfield-Youngstown area from 1928 until his recent retirement, specializing in physical medicine and rehabilitation; veteran of World War II during which he was a lieutenant colonel in the Army Medical Corps; member of the Exchange Club and the Episcopal Church; survived by three daughters, a son, and three brothers.

Carl Richard Wedler, M.D., Cleveland; Western Reserve University School of Medicine, 1903; aged 89; died January 12; former member of the Ohio State Medical Association and the American Medical Association; practitioner for some 43 years before his retirement in 1946; member of several Masonic bodies; survived by two sons and a daughter.

Makoto Yamaguchi, M.D., Cincinnati; University of Cincinnati College of Medicine, 1932; aged 63; died January 18; member of the Ohio State Medical Association and the American Medical Association; native of Chicago, and practitioner in Los Angeles before moving to Cincinnati in 1943; chief of intermediate service at the Veterans Administration Hospital, and clinical professor of medicine at the University of Cincinnati College of Medicine; member and elder in the Presbyterian Church; survived by his widow, a son, a brother, and five sisters. His brother and two sisters are physicians in Los Angeles.

Howard Haynes Yoakem, M.D., Columbus; Ohio State University College of Medicine, 1921; aged 76; died January 19; former member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons, and the International College of Surgeons; practitioner of long standing in the Columbus area and recently on the medical service of the Ohio Bureau of Workmen's Compensation; survived by his widow, two daughters, three sons, and a brother.

Ross Russell Zeno, M.D., Akron; University of Michigan Medical School, 1934; aged 61; died January 18; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; practitioner in Akron for some 32 years, specializing in general surgery; member of the City Club, the Catholic Church, Holy Name Society, and Knights of Columbus; veteran of World War II, during which he served in the Army Medical Corps; survived by his widow, two daughters, a son, his parents, four sisters, and a brother.

Billing for Treatment of Family Member

The Judicial Council of the American Medical Association recently issued the following statement regarding the provision of medical care to members of a physician's family: "From time immemorial it has been considered unwise and improper for a physician to treat members of his immediate family for other than minor health problems or in emergencies. For him to do so would be in violation of Section 6 of the *Principles of Medical Ethics* and therefore unethical.

"Even if for some good reason it becomes necessary to treat a member of his immediate family, a physician should not charge, or make a claim for, or receive compensation for such service from the patient or from a third party payor on the patient's behalf."

Woman's Auxiliary Highlights...

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

ON A COLD BLUSTERY DAY in January, State Board members braved the elements to gather in Columbus for their mid-winter meeting. You have to admire these gals—they pulled off their warm boots and coats, had a quick cup of coffee, and, forgetting the cold miles behind them, were soon ready for the business at hand. The long agenda looked impossible, but President Ruth Meltzer wielded her gavel with authority and much was accomplished.

Mrs. Meltzer reviewed her travels since Fall Conference and described the mountain of mail awaiting her after each trip. Now she is concentrating her attention on plans for the Annual Meeting. Make a note on your own calendars to attend the convention in Columbus, May 11-15.

District Directors Report

The District Directors then brought us up to date on county activity. Since some of this has already been reported in the December *Journal,* only a few additional notes will be included here.

Currently, Mrs. Robert Ulrich, Second District Director, is working with officers of **Darke** and **Champaign Counties** to strengthen their organizations. She reports that **Miami County** held a most successful Christmas dance for nurse scholarships in December.

Mrs. Albert May, Third District, stated that **Allen County** has a very active group which gives priority to community service among its many projects. This is the third year for their program to educate teen-agers to the dangers of VD. They have recently been asked to help organize a drug abuse program for the county.

Mrs. May described **Hardin County** Auxiliary as a small but stable, enthusiastic, congenial group carrying out an interesting program under the capable leadership of Mrs. C. L. Johnson. Members are active in community health programs and in fund raising for AMA-ERF. **Marion County** is currently supporting two nurses in training, providing each with a loan fund of $800. A close working arrangement with the county Board of Mental Health has been achieved, and a program is under way to educate youth in regard to drug abuse.

Mrs. George F. Jones has scheduled a meeting in March with officers of the county auxiliaries in District 8. She reported current memberships of 67 in **Licking County,** 28 in **Washington County,** 17 in **Guernsey County,** 45 in **Fairfield,** and 60 in **Muskingum.**

Preliminary Statistics

Any attempt to report membership totals, financial balance, or AMA-ERF contributions here would be useless. Even as the respective chairmen and treasurers were giving their reports, verbal additions were being made by members present. "————————County dues are in the mail." "We are sending another AMA-ERF

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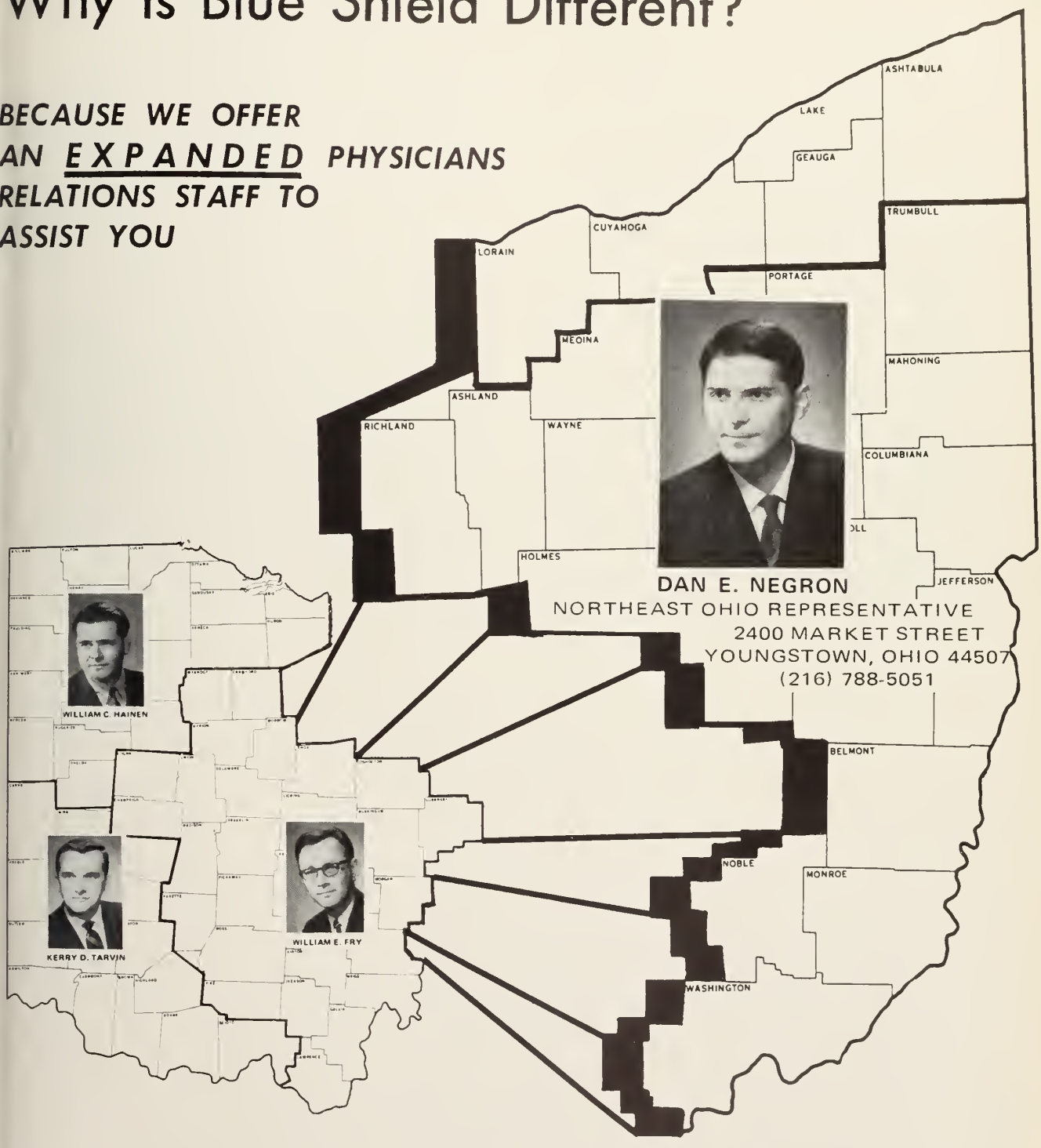
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check." "Ours hasn't been totaled." County treasurers and chairmen are urged to send in their dues and AMA-ERF funds as soon as possible.

New International Book Project

Mrs. Paul Woodward, Jr. reported on a new project which she is urging all International Health chairmen to consider. International Book Project, Inc., in Lexington, Kentucky serves as a clearing house for matching families or groups on a person to person basis with someone who lives abroad and wishes to receive English language books, journals, or children's magazines. Mrs. Woodward has requested the Lexington office to send information regarding the project to Ohio's International Health chairmen.

Self-Defense for Women

Mrs. John W. Elliott, Safety chairman, stated that she had received orders from nine counties for a total of 540 Vigilante Whistles. In addition, Trumbull County has ordered 144 whistles directly from New York. The material on Self-Defense for Women has been requested by several more counties. Clinton County is planning to do spot radio announcements on self defense and safety.

Revisions Considered

After a much needed break in business for a satisfying lunch, Board members reassembled to tackle the proposed amendments to the Bylaws and suggested changes for the Standing Policy Rules. These had been prepared by the Revisions Committee, chaired by Mrs. Karl F. Ritter, at a meeting in December. After considerable discussion, appropriate action was taken by the Board on all proposals submitted.

Butler Health Careers Day

Every year the Woman's Auxiliary to the **Butler County Medical Society** and the Middletown Hospital cosponsor a Health Careers Day to acquaint area high school students with the careers of their choice. This year 163 students from six high schools participated in the program. They toured the hospital, observing employees in their normal performance of duties. There was ample time for questions regarding specific positions and types of work.

Greatest interest was in the field of professional nursing, with 43 students specifically signing up for this area. Other departments included physical therapy, x-ray, medical technology, prac-

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tical nursing, speech and hearing therapy, dietetics, medical records and pharmacy. In addition, arrangements were made for students to visit with dentists and veterinarians in the city.

Assisting Mrs. William Neel, chairman of arrangements for the day, were Mrs. Peter Ammentorp, Mrs. Richard Dietz, Mrs. Marvin Max and Mrs. Gilbert Wagoner. Excellent publicity was secured in the hospital bulletin as well as two local newspapers.

Montgomery Initiates New Project

Health Careers Day has been a regular program in many other counties. Montgomery County reports that its Auxiliary has hosted approximately 1000 students each year for the past nine years. However, committee members have felt that they were not reaching all potential health workers and so decided to initiate a supplemental program—a narrated slide presentation.

Mrs. Jack Weiland wrote me a detailed account of the trials and tribulations of the project! There isn't space to include it here, but I would be happy to send a copy to anyone requesting it. In brief, the auxiliary committee (Mrs. Weiland, Mrs. Jaques O'Hara, Mrs. Ernest Fox and Mrs. Douglas Shanahan) contacted representatives of each professional and paraprofessional field, requesting information and slides most descriptive of each field. Then they arranged the slides and prepared a script. The Medical Society furnished a carrousel projector equipped with a synchronizer to a tape recorder that could be loaned to schools. A local announcer taped the actual narration which provides 45 minutes of description illustrated by 275 slides. The auxiliary now plans to schedule the program in as many of the 130 schools in the area as possible.

News Notes from Other Counties

The first 1970 meeting of the Woman's Auxiliary to the **Scioto County Medical Society** was held in the home of Mrs. Jerome R. Sheets. Mrs. Robert Newman discussed the art of wood carving. Assisting Mrs. Sheets on the hostess committee were Mrs. James F. Scott, Mrs. Milton Levine and Mrs. William E. Daehler.

The Woman's Auxiliary to the **Stark County Medical Society** held its annual style show and luncheon at the Imperial House on February 16. Mrs. Mark Herbst served as reservations chairman.

Mrs. W. P. Mazur, program chairman, arranged a special program for **Hamilton County** auxilians and their husbands late in January. Taking advantage of Margaret Mead's presence in the city for another event, Mrs. Mazur scheduled a dinner meeting with the internationally known anthropologist. Dr. Mead presented a documentary film of her revisit to the Admiralty Islands and answered questions about the trip. Assisting Mrs. Mazur with arrangements were Mrs. Khamis Saba, Mrs. Manuel Rodarte, Mrs. Thomas R. Werner, Mrs. Donald E. Gunderson and Mrs. H. Hudson Baumes.

The regular meeting of the **Women's Auxiliary to the Academy of Medicine of Cincinnati** was held at the Queen City Club on January 20. Dr. Kornel Huvos, associate professor of romance languages and literature, University of Cincinnati, discussed "La Femme Americaine," or what the French think about American women.

News Flash from Cleveland

Mrs. C. A. Colombi has recently been appointed to the Governor's Committee on Employment of the Handicapped, following creation of that committee by Senate Bill 107 at the last assembly.

Provisions in the OSMA Bylaws Pertaining to Nomination Of President-Elect

Attention is called to provisions in the Bylaws of the Ohio State Medical Association pertaining to the nomination and election of the President-Elect at the OSMA Annual Meeting. The President-Elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Columbus, May 11-15.

Nominations of the President-Elect are to be made 60 days in advance of the meeting at which election takes place and information on nominations published in *The Journal,* unless these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 12.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 1 (a), entitled "Nomination of President-Elect."

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Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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For Roster of County Medical Societies
See Issues of Alternate Months Beginning with February

Deadline for Submission of Resolutions to Columbus Office of the Association Is March 12

DELEGATES to the Ohio State Medical Association and County Medical Societies planning to have resolutions submitted for consideration by the House of Delegates at the 1970 Annual Meeting should be guided by the following Constitutional requirements:

1. Resolutions, regardless of whether they have been submitted in advance and published in *The Journal,* must be introduced at the first session of the House of Delegates, Monday evening, May 11, at the Columbus-Sheraton Hotel, Columbus.

2. When the resolution is introduced, copies in triplicate should be presented.

3. To be eligible for presentation, a resolution must be filed with the Executive Secretary of the Ohio State Medical Association, Columbus, at least 60 days prior to the first session of the House of Delegates, namely, not later than March 12. This requirement may be waived by a two-thirds majority of the House of Delegates.

4. Resolutions received will be published in *The Journal* prior to the meeting. Also copies of resolutions will be distributed to members of the House of Delegates to give them an opportunity to discuss issues with their constituents and possibly receive voting instructions from their County Medical Societies.

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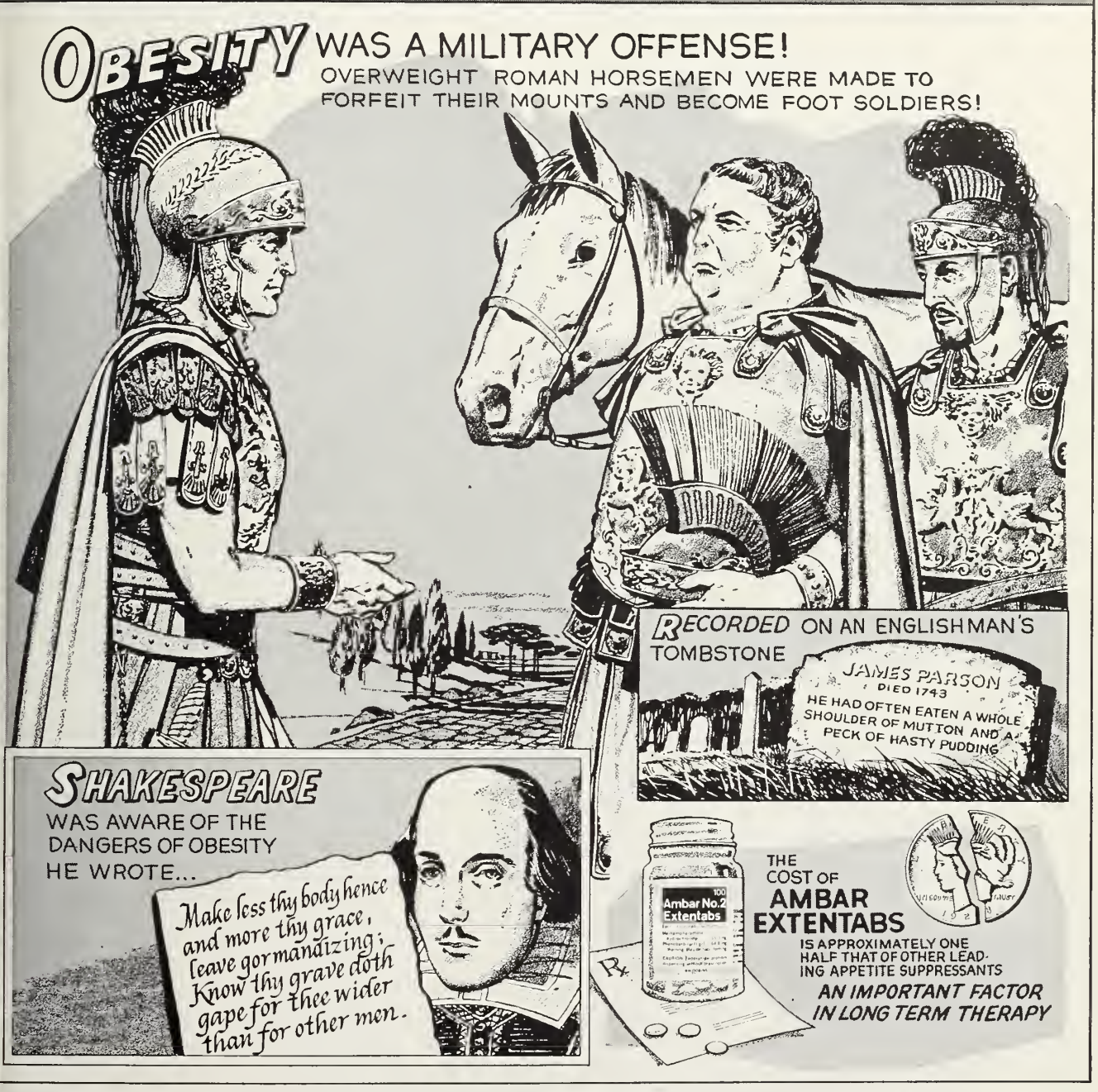
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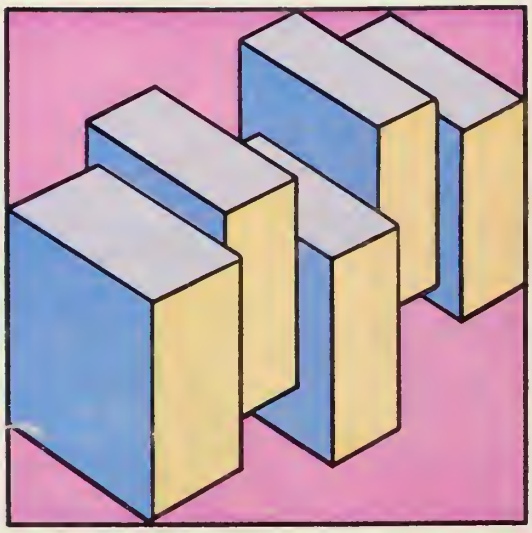
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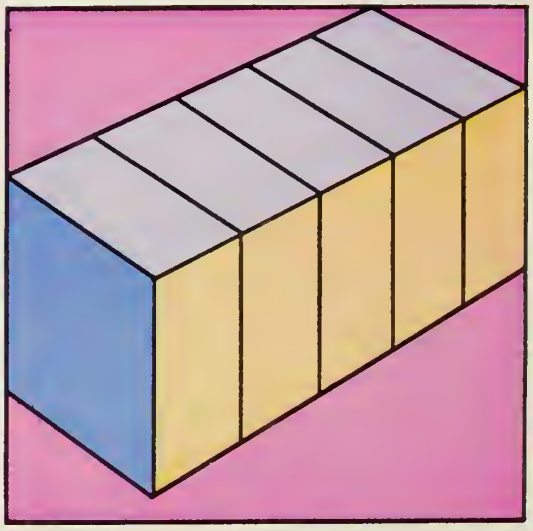
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APRIL 1970
Vol. 66 • No. 4

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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Roger O. Egeberg, M.D.

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Hear Him
at the OSMA Annual Meeting
Wednesday, May 13, at 2:00 p.m.
(See Page 402)

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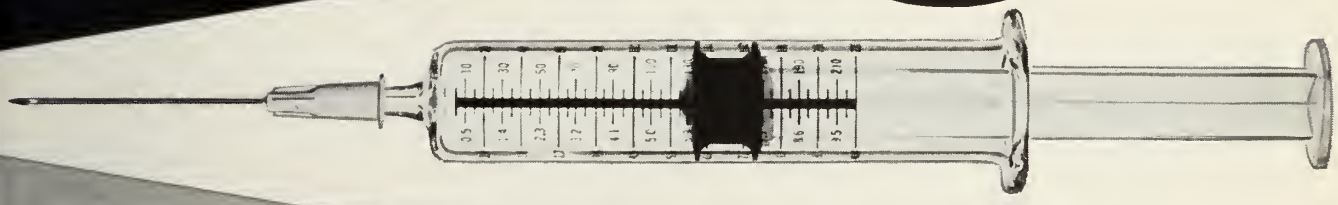
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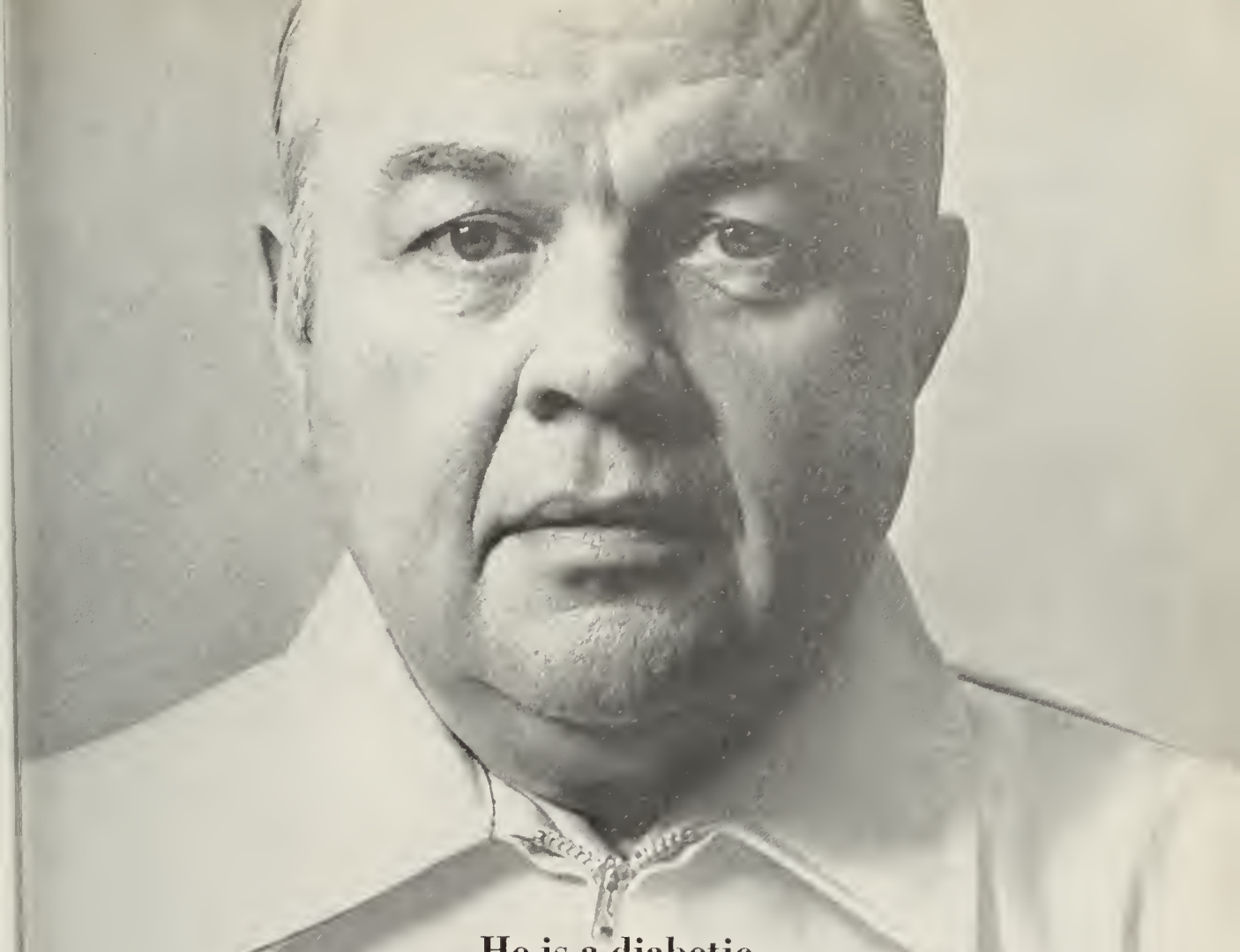
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Peer Review

By Richard S. Wilbur, M.D.

PEER REVIEW! A popular term these days. First, though, what does it mean? Literally it means a review by one's equals. Therefore, it means to us a survey of a doctor's work by other doctors.

Then why do we need this peer review so desperately? The answer to this question itself becomes a multiple series of problems. They begin, of course, with government — specifically with Titles XVIII and XIX which were passed in Public Law 89-97. While the Medicare Law only calls for inhospital utilization review, experiences in the last three years have shown that far more is needed. There has been the well publicized increase in health care costs so that at the September meeting of the Medicare Health Insurance Benefits Advisory Council, the following statement was presented:

> "In order to provide an acceptable level of quality for the services rendered under Part B of Medicare, consideration should be given to establishing standards to govern the rendering of services by physicians, analogous to, but necessarily quite different in application from, the standards now established for most other providers of health care under Medicare. The need for broad standards for physicians' services is predicated upon the right and responsibility of the government to have assurance of the acceptable quality of all services for which it provides reimbursement. Precedents which have been set in government and nongovernment programs, and published studies, which point out the wide variability in quality of medical care, indicate the need.
>
> "Thus, the standards of eligibility for physicians would be a 'preventive' measure to keep some physicians from ever rendering certain medical services under the Medicare program. This differs from the 'post facto' stopping of abusers of the Medicare program. The latter may involve a few physicians, those who are grossly abusing the program. The former could potentially involve the future participation of many of the practicing U.S. physicians in the rendering of certain medical services under the Medicare program."

Reasons Why

The first answer to the "why" of peer review then is a very practical one. Government must be assured that it is getting its money's worth for all the billions it has spent with these large programs. No man can be elected to public office on a platform in which he agrees to allow the expenditure of unlimited and unchecked sums of money for any purpose — even for the health care of the American people. All of us are taxpayers and all of us would like to think that the money which we give up to our government is truly buying something worthwhile. The nonphysicians of the country have been convinced by what they read in the newspapers that they are no longer getting their money's worth for taxes spent on Medicare and Medicaid. They want, rightfully, some proof.

There are still other reasons we need to have peer review. One is malpractice. This is an ever-growing problem in some areas such as Southern California where premiums of $5 to $16 thousand a year are now being paid by doctors who have never been sued. The problem is acute. Over and over the point is made that the public is not assured that medical care is of high quality. Therefore, the allegations and accusations of the plaintiff's attorney fall upon open ears and juries are quite willing to believe the worst about all physicians. If they knew that an adequate mechanism of peer review existed which assured them of the quality of health care this problem could be alleviated as it has been in areas such as Tucson, Arizona.

The third reason why we need peer review comes from the press. The press has been quite willing to assign the responsibility for all of the rise in health care costs to the physician because it includes the vast portion which is paid to institutions, particularly the hospitals and extended care facilities. If we physicians are to take the blame for the expense, the least we can do is to take the responsibility for supervising this expenditure. In other words, we will have to supervise the utilization and, beyond that, even the efficiency and the quality of care given by the hospitals and the extended care facilities as well as that given by physicians. In some areas this

Dr. Wilbur, of Chicago, is Assistant Executive Vice-President of the American Medical Association. This article is based on an address given by Dr. Wilbur before the Council of the New England State Medical Societies, November 5, 1969 in Boston, Mass.

review has been extended also to the ordering by physicians of such services as physical therapy and even to the prescribing of medications — 95 percent of all health care expenditure.

The fourth reason, however, is the most important and that is the problem of satisfying the American people — the patients of the doctors of America — that they are receiving the highest possible quality of care. Let me say that I am not concerned about your particular patients. The mere fact that you are the kind of a physician who has enough interest to read an article on this subject is proof enough that you are not the kind of a doctor whose patients need this assurance. Unfortunately, there are many other doctors who have not and who won't go to medical meetings, conventions, or continuing medical education. These are the men whose patients are uneasy — sometimes with good reason. The question, therefore, becomes not if we need medical care review, but who will do it?

Review of Quality Under Medicare

The Cost Effectiveness Act of 1969, which has been sent from HEW to the House of Representatives, contains a number of provisions for federal review of quality under Medicare. Some of these include, as did Walter McNerney's Medicaid Task Force Report, suggestions for federal licensure and federal standards. So it now becomes very clearly a matter which will be handled by government, if no one else steps forward first. However, we have seen in the past, situations in which the government was quite willing to accept voluntary standards. The Joint Commission on Accreditation and our specialty boards are two cases in point.

You might then ask whether there is any precedent for doctors in their organizations to engage in review of the quality of health care. There certainly is! The AMA virtually since its inception has been opposed to low standards as exemplified by quacks and chiropractors. Even before the Flexner Report, and certainly very much since then, we have been concerned with the quality of training in medical schools and with the accreditation of internship and residency programs. We have worked to improve the quality of drugs since 1900.

Within the local medical societies there have been rather elementary forms of peer review for many years. Most societies have some form of insurance review committee. This committee's activities vary from place to place, but in general, it adjudicates fees and makes some effort to explain why the fine print in an insurance contract means that the company does not have to pay the patient for the physician's work. Most local societies also have grievance committees. These, of course, take care of complaints, be they from patients, third parties or other physicians. Both of these types of committees are largely of the brushfire type, i.e., they do not go into action until long after a problem has occurred and not until after someone else brings it to the attention of the medical society.

Another form of peer review with which we are all familiar is that in the hospital with its credentials committee, medical records committee, tissue committee, and utilization review committees. The current AMA position on peer review can be summarized with the following quote from Report F of the Council on Medical Service to the Annual Meeting in New York this year:

> "For more than a decade, the Council on Medical Service and its Committee on Health Care Financing (formerly the Committee on Insurance and Prepayment Plans) have recognized a need for the establishment of professional review activities by medical society review committees and utilization review committees of hospital medical staffs.
>
> "Initially, this interest was generated by concern over the continuing increase in the costs of health care, particularly for hospital services, and the resulting steadily rising rates required from the public for health benefits protections. In accepting a responsibility for professional review activities, the medical profession has demonstrated its awareness of the need to conserve the patient's health care dollar, educate and inform the profession in the economies of health care, assure the appropriate use of health care personnel and facilities, and maintain high standards of medical practice."

Future Outlook

What is the future purpose of peer review then? Sometimes it is easier to start out by saying what it is not. It is not being a cop and it is not simply performing as a government agent to save tax money. The main purpose is to assure the public of the quality and effectiveness of the health care being given in that area. There are also side purposes of considerable importance, however, such as education. There is much which the person being reviewed can learn. As an example, the American Association of Medical Clinics in the last few years has set up an arrangement in which several doctors leave their practices in their different clinics and gather to spend two days inspecting a specific clinic. They do not do this as policemen who have been called in by the AAMC or by government to check on some questionable practices. They only do it when the clinic being surveyed requests such a visitation. In

fact, the clinic which is surveyed pays all the expenses.

Since they do not need this investigation in order to be a member clinic, don't get any fancy certificate, and don't get any increase in the fees they can charge, you may wonder why they bother. The answer is that any group which wishes to improve, and I have never seen one yet that was close to perfection, can only benefit from a critical review by informed fellow physicians. So far, each group reviewed has thought that it was more than worth the effort and expense.

You might also ask why a doctor would leave his practice for a couple of days to go prowl through another clinic. The answer here involves more than altruism. It is impossible for an intelligent man to spend two days watching other doctors practice medicine without learning something which will be to his benefit. Remember, you never had a medical school course in how to run an office. Whether you are in group or solo practice, it is doubtful that you are so efficient that you could not learn even better ways, either by having another doctor visit you or by your spending time observing his practice.

So the purpose then is not just to save taxpayers money, not just to assure the public of quality and effectiveness, but also a form of continuing medical education for both the reviewer and the reviewed.

The next problem we face is: what is it we should review? It seems obvious from the past discussion, we must review all there is of medical care, at least, and very possibly in the future, all there is in health care. Certainly we must review the medical treatment given in hospitals and extended care facilities. More recently it has become increasingly obvious that, like it or not, we must also review the medical care given in the office. It may be difficult, but it is certainly essential.

Next, you might ask, what are we looking for? First, of course, is fraud which in medicine is no different from any other kind of fraud and the duty of the peer review team is no different from that of any other honest citizen. Fortunately, this is rare and soon taken out of the hands of the physicians. The next item for which we look, of course, is the unfair fee, something we have done traditionally for many years. Beyond that, we must now begin to look at utilization — that is the number of services rendered and even beyond that to the efficiency and quality of care rendered. It no longer is enough to tell people that they have not been cheated or just that the fee for a given service is not too high. They need assurance that they are receiving a good quality of care for the money they spend.

Techniques for Meaningful Review

The last question is probably the hardest. Once we have decided that review is necessary, what techniques can we use to make this review truly meaningful? How do we do it? The traditional technique for peer review has been the use of a Grievance Committee or Insurance Review Committee which simply look at those physicians about whom there has been a complaint — usually already known to all the doctors in the area.

But, what we're speaking of now goes well beyond this system. In a number of parts of the country it has been possible, particularly under the government programs, but not only under them, to do a form of total claims review by computer. This will give a gross review of a man's practice. From this can be developed a number of statistics: the number of visits per day; the number of visits per patient; the number of visits per diagnosis; the number of shots given per visit; the number of lab x-ray tests per visit; and from this, one may obtain an over-all view of a physician's practice.

Dr. Donald Harrington of the San Joaquin County Foundation has done a great deal of work on this, initially only on private insurance company contracts, later on Medicaid as well, and has been able to set up parameters of electronic observation which have enabled him to spot "deviant practitioners." Those doctors who have an unusual number of injections per patient visit in the office or others who never seem to be able to see a patient without doing a urinalysis or blood count, those who must see a patient two or three times a week for a rather routine diagnosis such as osteoarthritis, etc. Doctor Harrington would be the first to tell you that you can not leap to conclusions simply from a computer analysis.

There are all sorts of reasons for variations from the norm in practice. The mere fact that a man practices in a different way is no proof at all that he is a "bad" practitioner. In this country, and particularly in medicine, uniformity and conformity are not necessarily the ideal.

There are other reasons for the inherent errors in the computer method including local variations particularly the differences in style of practice between rural and urban doctors and of the disadvantaged areas versus the middle class suburbs.

The Human Element

The next step must always be to pull out the original claims forms for review. Here one can look over the number of tests ordered and paid for on the basis of the diagnosis and also the amount of treatment and its relevance to the diagnosis placed upon the claims form. Once the peer

review committee has gone through the computer analyses, selected from it those claims forms it needs for review, and then reviewed these forms from unusual practitioners, it still has not established the fact that the doctor involved practiced a poor quality of care.

Let me give you an example. In my former county, Santa Clara, we have a moderate size city, San Jose, with some 400,000 citizens. The city is split by Highway 101. On the West side of the highway are the English speaking citizens, generally from the lower middle class on up. On the East side of the highway are the Spanish speaking citizens, usually of lower income groups. In reviewing claims under our Medicaid program, which review is done by the County Medical Society, we found the Spanish speaking doctors East of the highway invariably gave penicillin injections to children with a cold. We Anglos, of course, were certain we had spotted an obvious abuse of the program. A group of men who were committing malpractice simply in order to collect extra funds for giving shots under the program. A committee of righteous, outraged county society members descended upon our Spanish-speaking confreres in order to bring the wayward brothers back into the fold. Well, the message was delivered alright, but it was we who got the message.

It appears that in this type of community, among the lower income Mexican-Americans, faith in physicians is erratic and on a semimystical basis. The doctor is given one chance at the illness. When the baby has a cold, he and the rest of the family are bundled up and brought into the doctor. Whatever the doctor does is fine with the mother, but no matter how much sicker the child gets afterward, he will not be brought back since there is not any reason to. "He's already seen the doctor." Further remedies are likely to include prayer or forms of folk medicine.

Furthermore, the mothers have very little faith in pieces of paper or long explanations. Telling the mother that she should take a prescription and fill it at a drug store and then to give pills to the child if he should get sicker, simply results in another piece of scrap paper in the waste basket by the front door of the doctor's office. Even giving samples of pills to be taken later is no assurance that the child will receive any further treatment. Therefore, if there is any possibility that the baby may develop bacterial bronchitis or pneumonia from the cold, the only assurance that he will survive is for the physician to actually place the penicillin into the child himself.

While we may all hope that in the future education and an elevation of income level will change this situation, for the present it continues to be malpractice or at the very least poor medical practice to give penicillin for colds in the English western half of the city while it is malpractice not to do so East of the highway.

View from the Grass Roots

There are many other examples, all of which add up to mean that the review of quality can only be done locally, it can only be done by people who can understand the variations and circumstances, which in the end means that it can only be done by other local physicians. It must be done by physicians, because lawyers for instance are so bound by technicalities that common sense or what is best for the people rarely enters their minds and to allow them control of the program would be disastrous.

For example, in one of our large cities in California, it became evident after a period of review that of eight minority doctors in one area, six were abusing the programs through over utilization. Too many injections per patient visit, too many laboratory tests, etc. This assumption was reinforced by visits to their offices and therefore the county medical society recommended that they no longer be paid under the Medicaid program. The first two telephone calls to the medical society were from the other two minority physicians — the "good" doctors in the area. They were terribly unhappy. "Are you trying to kill us? There are too many Medicaid patients already for the eight of us. Two of us even working 24 hours a day couldn't possibly handle the load, and we certainly couldn't give any quality of medical care. You must keep the other six doctors working for the good of the people of our part of the city."

The Medical Society was understandably reluctant, but it also was understanding of the problem on the basis that even over-utilized medical care is better than none at all. Those doctors were reinstated in the program, although the County Medical Society has since attempted a practice educational process for them. Again, what this adds up to is that there must be local control of the program, there must be local understanding of local problems and there must be an interest on the part of physicians of the Medical Society in seeing that medical care is given to the people.

Summary of Remarks

Let me make a summary about the benefits to be derived from this program. I have mentioned the direct benefits, of course, to the taxpayer, to the reviewing physician and to the physician who is reviewed, but there are other benefits, one of these comes from publicity. It is no secret that the medical profession has a "bad image." The knowledge that the doctors in the County Medical Society are spending hours reviewing the quality of care can only do good

things for us. In the past, as you know, we have only allowed publication of bad publicity about doctors, so it is not surprising that we have a poor image.

In the past, if the doctor did something good for a patient, we have forbidden this news to be printed because we felt it amounted to advertising. However, if something bad happened — a drunk driving conviction or malpractice suit — nothing the Medical Society could do would ever keep the news out of the paper.

For this reason, our patients have read only unfavorable things about doctors and naturally formed that kind of an opinion. I might suggest as an aside to the principal subject that we may have to reconsider our entire concept of physician publicity. However, whether we need to change our attitude toward publicity or not, there can be no doubt about our need for peer review.

The People of this country deserve to know their medical care is all it should be. The best guarantee of this can be given only by the concerned physicians of an area working together in an effective program of Peer Review.

1. Congress demands it;
2. Our patients deserve it; and
3. We need it.

Army Looks to Cincinnati for Laser Studies

U. S. Army men from all over the nation are coming to the University of Cincinnati Medical Center for week-long courses in laser theory, applications, and safety. The course has been tailor-made for the servicemen by UC's Laser Laboratory.

A number of universities were asked to plan and submit programs to the Army Materiel Command Safety Office, Washington, D.C., after the AMC found that there was no course in existence which fulfilled its needs. The course proposal submitted by UC's Laser Laboratory was selected by AMC.

Six courses are being presented, each lasting five days and limited to 30 Army specialists. They are held in the new Cincinnati General Hospital, major teaching hospital in UC's Medical Center. (The Laser Laboratory itself is located in the Children's Hospital Research Foundation.)

The courses are given under auspices of the Cincinnati CONMED program of continuing medical education, directed by Dr. James F. Schieve, assistant dean in UC's College of Medicine.

Case Western Reserve Joins in Caribbean Project

Case Western Reserve School of Medicine will join three other schools in an effort to solve some of the health problems in the Caribbean, it was announced by Dean Frederick C. Robbins. With Harvard Medical School, Yale School of Medicine, and the University of West Indies at Mona, Jamaica, CWRU has formed a Consortium for Health Work in the Caribbean which will include students, faculty and staff of all four institutions in collaborative research efforts on specific projects.

The new program is the second involvement in the Caribbean area for the CWRU Committee for International Medicine headed by Dr. Kenneth S. Warren, associate professor of medicine and preventive medicine. Last summer a group of CWRU faculty and students spent two months at the Rockefeller Bilharzia Institute on St. Lucia in the Windward Islands — the first year of a three year research project on schistosomiasis.

Objectives of the newly organized Consortium will be participation in the solution of specific problems, strengthening of academic institutions in the Caribbean, training of U.S. medical students in epidemiology and research in tropical and other diseases, and increased faculty and student exchange between the Caribbean and the United States.

Physicians of State Agencies Elect Officers

Following the January 9 meeting in Athens of the Association of Physicians of the State of Ohio, the following officers for 1970 were announced:

President, Mortimer Hacker, M.D., Toledo State Hospital; first vice-president, Russell Long, Ohio State Reformatory, Mansfield; second vice-president, Kurt Lessy, M.D., Fairfield School for Boys; third vice-president, Michael Zannoni, M.D., Sagamore Hills Children's Hospital; fourth vice-president, Fortunato Soriano, M.D., Columbus State Hospital; secretary-treasurer, Virginia S. Edwards, M.D., Cleveland Psychiatric Institute. This is the thirteenth year that Dr. Edwards has been secretary-treasurer.

The next meeting is scheduled at Hawthornden State Hospital, Cleveland, April 10 beginning at 9:00 a.m.

Future meetings are scheduled as follows: July 10 at Lima State Hospital; October 16, Columbus State Hospital; and January 8, 1971 at Lebanon Correctional Institute.



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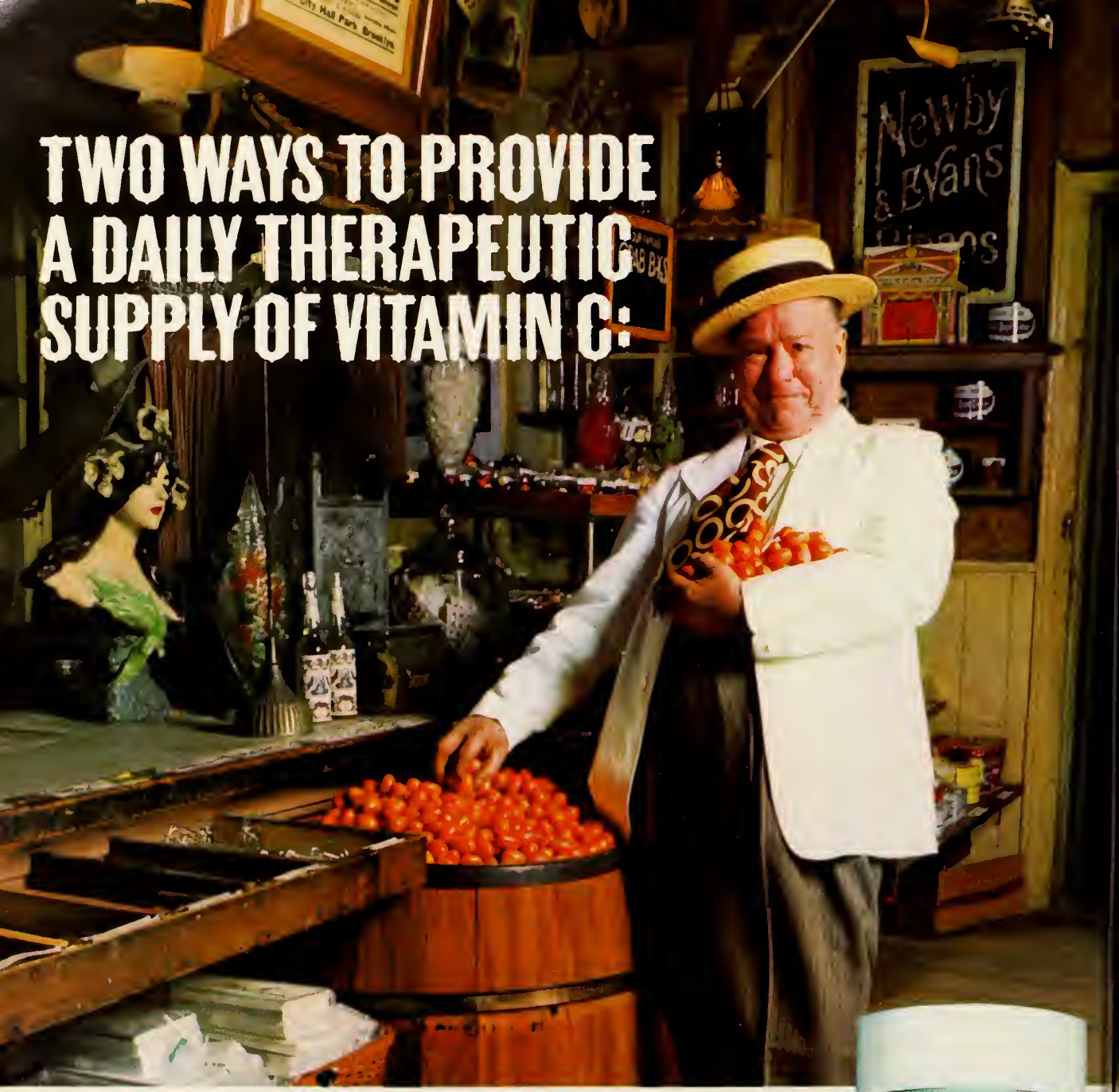
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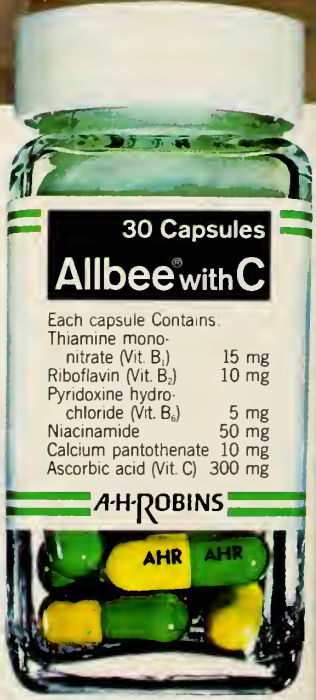


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REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

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Letters to the Editor

Editor's Note: Up dating of *The Journal's* cover and format met with enthusiastic response on the part of physicians and medicine's friends in allied services. Most of the favorable comments were verbal, but we were fortunate to receive a number of written messages. The following letters and excerpts are examples.

"Just a note to let you know that I have received the new format of *The Ohio State Medical Journal.* I have been intending to write to you for sometime to tell you how much I enjoy the change and I think that whoever is responsible for it has done an outstanding job.

"I have been confined to my home for a long period of time and have not been active. As a matter of fact, I am forbidden any activity of any kind.

"If you are in Toledo sometime or other, I would be very happy to see you.

"Mrs. McCormick joins me in sincere regards and we hope that everything in Columbus is going along ship-shape. I have no doubt that this is the case."

Sincerely yours,

(Signed) Edward J. McCormick, M.D.

(Dr. McCormick is Past President both of the Ohio State Medical Association and the American Medical Association. His address is 4350 Northmoor Road, Toledo 43615).

"Congratulations on the new format for *The Ohio State Medical Journal."*

"We all look forward to the February issue . . ."

Walter S. Page, Jr.

(Executive Secretary, Ohio State Heart Association.)

"I like that 'New Look' very, very much.

"It's effective and attractive and I congratulate you.

"Using 'Medicine's Message to a Lay Audience' was another departure that I particularly liked. I realize that *The Journal's* primary purpose is in matters scientific — but I do feel strongly that doctors should become 'indoctrinated' in reaching lay groups. It's so very important that they know how to communicate."

Sincerely,

(Signed) Ruth Meltzer

(Mrs. Meltzer, of Portsmouth, is President of the Woman's Auxiliary to OSMA.)

"Let me congratulate you on the most refreshing, informative, and enlightening issue of *The Ohio State Medical Journal* ever.

"If the present format is not greeted with enthusiasm throughout the state, it will be most surprising. If the material in the most recent issue is indicative of what we may anticipate, in the future, I would have to be of the opinion that the future augurs well for *The Journal.*

"I feel success will be yours.

Very truly yours,

(Signed) George N. Bates, M.D.

(Dr. Bates, of Toledo, is OSMA's Fourth District Councilor.)

"*The Journal* arrived today, with its new cover and all the changes.

"It certainly looks good in new dress. The effort must have taken a lot of work, but it is worth it.

"Congratulations to all who labored on the new look."

Jayne Ellison

(Medical and Science reporter for the *Dayton Daily News.*)

"Altho I practiced medicine and surgery for nearly 50 years, I was forced to retire because of arthritis in my knees, but I still try to keep

up in medicine by reading my journals. I like the new cover on *The Journal* and look forward to receiving it every month."

Sincerely,
John Earl Briggs, M.D.
Columbus

"Congratulations on the change made in *The Ohio State Medical Journal.* It meets with my approval 100 percent."

Sincerely yours,
William W. Trostel, M.D.
Piqua

"Your January issue arrived today.

"The 'new look' is just great and we all send our congratulations."

State Medical Journal Advertising Bureau (Chicago)
Charlotte, Cathy, Miriam, Janet

"I am writing to indicate my favorable impression of the new change in the format of *The Ohio State Medical Journal.*

"It's nice to see a variation, and I think that it is for the better. Keep up the good work."

Sincerely yours,
Tom F. Lewis, M.D.
Columbus

"A copy of the February 1970 issue of *The Ohio State Medical Journal* has just come to my attention. We appreciate very much your generous use of a number of articles prepared for the American Heart Association. On our behalf, as well as the Ohio State Heart Association, we thank you very much."

James M. Hundley, M.D.
Executive Director
American Heart Association, Inc.

"I was very pleased to see, in the February issue of *The Ohio State Medical Journal,* the nine clinical features on the heart presented in pages 137-157.

"Although these articles provided by the American Heart Association have been used as single items in several state medical journals in the past, *The Ohio State Medical Journal* is the first to put several of them together as a feature presentation.

"On behalf of the American Heart Association, and I am sure with the endorsement of the Ohio State Heart Association, may I express our appreciation for this effective and innovative use of these materials."

Campbell Moses, M.D.
Medical Director
American Heart Association, Inc.

"On behalf of the Ohio State Heart Association I would like to express my appreciation for the heart articles published in the February issue of *The Ohio State Medical Journal.* These articles are excellent and effective in furthering the education of Ohio physicians."

Sanford R. Courter, M.D.,
President, Ohio State Heart Association

Ohio Ranks High in Traffic Toll

Ohio had the dubious distinction of being the fourth highest state both in number of traffic deaths for the year and the fourth in the rate of traffic deaths according to population.

The number of Ohio traffic deaths in 1968 was 2,555, or a rate of 23.9 per 100,000 population, according to figures recently released by the Ohio Department of Highway Safety. As might be expected, the death toll was only one part of the grisly picture. There were 103,739 traffic injuries. Unfortunately, published figures do not show how many of the accidents resulted in permanent injury. Property damage amounted to $108,200,000 and the estimated economic cost of traffic accidents has been placed at $510,000,000, or about $50 for every man, woman, and child in the state.

The problem is big. There are over six million registered vehicles in Ohio and they cover some 52 billion miles of travel in a year. Fatalities decreased in 37 counties from the previous year, but those decreases were offset by increases in 45 other counties. Motorcycle accident deaths dropped after Ohio enacted stricter operating regulations. Figures on Ohio's drinking-driving picture are incomplete. Alcohol was a factor in about 40 percent of the fatalities listed in rural state highway accidents.

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Malpractice Insurance

Past, Present, and the Uncertain Future

By Charles F. Price
Director of Economic Research
Ohio State Medical Association

MOST PHYSICIANS are becoming increasingly alarmed about the subject of professional liability. Their concerns are justified: premium rates are skyrocketing, the chances are that one doctor in five will have at least one claim filed against him during his professional career, and some "high-risk" and/or malpractice-prone physicians are unable to get coverage at any price! Congress and some state legislatures have also expressed concern. The report, "Medical Malpractice: the Patient vs. the Physician," of Senator Ribicoff's Subcommittee was 1,060 pages in length.

It is not difficult to document the soaring costs of premiums which began in 1967. On November 22, 1967, the American Medical Association estimated rates had increased from 10 to 50 percent in 20 states. This was the first general increase since 1959. In October, 1969, the Nettleship Company increased rates in the Los Angeles area by 110 percent and premiums for general surgeons went from $1,900 annually to $3,900.

The Insurance Rating Board rates were recently increased as indicated in Table 1.

Ohio physicians have been somewhat more fortunate than their colleagues in some other states. Table 2 indicates the rate increases and percent of increases since January 1, 1966, for the company that writes malpractice insurance for the majority of the doctors in Ohio.

Insurance Companies' Viewpoint

The reasons for the accelerated increase of premium rates is easy to document. Insurance companies allege they are losing money on malpractice insurance. Lloyds of London and many of the largest companies who have written malpractice insurance have withdrawn from the market. One insurance company executive in California contends that no company has made money on malpractice insurance since 1953, and the consortium of insurance companies in California has lost $20 million in recent years. An executive of Aetna stated that his company has lost $10 million on malpractice insurance since 1968. A complicating factor is that perhaps only the tip of the iceberg is showing. The experience of the carriers indicates that it requires about five years before claims, settlements, and suits are finalized. Because of the escalating number of claims and size of awards, the carriers' actuaries cannot project future costs; thus, it will be 1975 before they will know their costs for 1970.

It is also common knowledge that the amount of awards granted to successful plaintiffs has been increasing. In California recently there have been awards of $1,200,000.00 and $1,400,000.00. Two awards made in Florida exceeded $1 million each. One authority has estimated that 1969 experience will show that the average award made for treatments during 1969 will average $69,000 per successful claim. (It is interesting to note that some authorities estimate that only 30 percent of the claims will have any merit.)

Although most authorities are agreed that the number of claims have been increasing, there is little published documentation. The carriers are naturally reluctant to have their actual experiences published. However, Aetna Life and Casualty has said that the number of claims has increased 43 percent in the past five years. During this period, the average cost per claim jumped 200 percent.

The view has been expressed that there are unquestionably more claims because the volume of medical services performed has increased con-

Table 1—Insurance Rating Board rate increase:

Class	Prior to 12-17-69	After 12-17-69	$ Increase	% Increase
1	$176.00	$305.00	$129.00	73.2%
2	$308.00	$535.00	$227.00	73.7%
3	$528.00	$1157.00	$629.00	119.1%
4	$704.00	$1542.00	$838.00	119.0%
5	$881.00	$1928.00	$1047.00	118.8%

20% surcharge for groups and partnerships.

TABLE 2. Ohio rates for $100,000-$300,000 limits coverage by the insurance company that has the majority of Ohio M.D.'s as clients.

Area #1	Jan. 1, 1966	Jan. 1, 1970	$ Increase	% Increase
Class 1	$64	$137	$73	114%
2	$80	$176	$96	120%
3	$187	$487	$300	160%
4	$278	$818	$540	194%
5	$381	$1189	$808	212%
Area #2				
Class 1	$58	$127	$69	119%
2	$72	$158	$86	119%
3	$157	$409	$252	160%
4	$247	$728	$481	194%
5	$309	$914	$605	196%

Area # 1 consists of the following counties: Ashtabula, Cuyahoga, Franklin, Geauga, Lake, Lorain, Lucas, Mahoning, Medina, Portage, Richland, Stark, Summit, and Trumbull.

Area # 2: Rest of State.

Please note: The above comparison is that of 1966 vs. 1970. The increases in premiums were only about 25 percent in 1970 vs. 1969.

siderably in recent years because of Medicare, Medicaid, increased participation in private health insurance, and the increases in population. In testimony before the Ribicoff Subcommittee, Richard P. Bergen, director of AMA Legal Research Department, said, "My feeling, which I can't prove or disprove, is that the actual number of suits has increased, but the rate of suits per units of patient care has not increased."

Causes for Increased Claims

There are several causes for the increased number of claims and size of the dollar awards:

1. There has been a breakdown in the traditional patient-physician "rapport" caused by the defendant doctor. This includes fee disputes, defective records, concealment of facts, and inadequate consent. A contributing factor may be that doctors with high patient loads may not be spending as much time with individual patients as they did formerly.

2. The attitude of the patient towards the physician and the profession in general has changed. The increased mobility of the population leaves little time to establish sound doctor-patient relationships. Also contributing to the problem has been the publicity given to huge awards, and T.V. programs. Another adverse factor has been the publicity on new drugs, vaccines, transplants and other surgical procedures which leads the public to expect too much. As a result of this journalistic "conditioning", patients are decidedly more prone to blame the treating physician whenever the outcome of the course of treatment proves unsatisfactory. Some students of the problem add that patients have been led to believe that doctors' earnings are high and they resent it.

3. There has been considerable controversy as to the impact of the contingency fee system on the increasing number of claims. It seems agreed that of every award or settlement that ⅓ to ½ is going to the lawyers. In January, Health, Education and Welfare Secretary Finch was quoted as saying that he "has special insight into the problem (malpractice) because he supported himself on such suits in the early days of his practice".

4. Many courts have taken a more liberal stance in recent years. The most outstanding example of this is that California and other state courts are now using the doctrine of "res ipsa loquitor" ("the thing speaks for itself"). The unconditional application of this doctrine puts the burden on the defendant, and unfairly fails to reconcile situations which are rare accidents, those which are calculated risks, and those of negligence. This doctrine has not been accepted by the courts of Ohio.

Other examples of the changing views of the courts are that California's Supreme Court has ruled that any doctor who does a specialist's work must perform at the same level of competence as the specialist, even if the doctor serves in a remote village, and performs surgical procedures with limited facilities, equipment and personnel. Also, in many states, the statute of limitations runs from the time of discovery rather than time of treatment. It should also be remembered that advances in medicine lead to more intricate and complex fields and surgical procedures where the risks are increased.

The Vicious Cycle

The general public should share the physician's concern about the malpractice situation. Physicians hoping to protect themselves are likely to order more than the usual number of x-rays and tests, hospitalize patients more readily, and call in more and more specialists to confirm

diagnoses. All of this adds to the costs of health care. It is also likely that some doctors will forgo performing certain diagnostic tests or treatment procedure for fear of being sued if something goes wrong. The Ribicoff Subcommittee Report contains this statement: "It is inevitable that increase in malpractice insurance rates will force physicians and hospitals to increase their respective rates and fees".

There have been several remedies suggested to solve the problem:

1. Group insurance for state association members. At least thirteen state associations (Minnesota, Georgia, North Carolina, Washington, D.C., Virginia, Illinois, Florida, Colorado, New Jersey, Oregon, Washington, and Tennessee) sponsor and endorse a particular carrier. However, a 1968 OSMA post card survey to determine the members' inclination to participate in group plan showed only 18.6% of the membership was interested.

2. The carriers, of course, believe that suits can be avoided by improved procedures with reference to surgical skills, judgements and the securing of informed consent and better rapport with the patient. One carrier estimates that one-half of all claims are avoidable.

3. Many physicians think that the number of suits would be reduced if the contingency fee system were eliminated or modified. Considering the number of plaintiff attorneys who are in the state legislature, or who have considerable influence with legislators, this remedy seems to have little chance of becoming law. However, it might be possible to secure passage of a statute which would establish a sliding scale of fixed percentages for plaintiff attorney's share of the award in a decremental manner. In other words, the plaintiff's attorney would receive a smaller percentage of a high award, and a higher percent in cases involving lower awards. Precedence has been established somewhat for this in that lawyer's fees are fixed by law in this manner in the settlement of estates.

4. There have also been many recommendations that would involve the use of a panel of experts, arbitrators, and compulsory arbitration, etc. The carriers and many authorities, view this recommendation with considerable alarm. They point out that this would not preclude a patient who is dissatisfied with the decision of the panel or arbitration board from taking his case to court. They further point out most emphatically that this would only serve as "fishing expedition" for the patient's attorney and, the information thus secured could be used to weaken the case of the physician when his suit was tried in court.

5. The California Medical Association has successfully sponsored five bills:

a. Plaintiffs have to post $500 cost bond which is forfeitable in the case of a "frivolous" claim.

b. Immunity is granted to all attendings who respond to a call by a hospital for resuscitation volunteers.

c. The proceedings of hospital utilization and tissue committees cannot be subpoenaed by plaintiff's attorney unless the defendant doctor was present at the committee sessions.

d. Insurers can make advance payments for medical care and other expenses before the issue of liability is resolved.

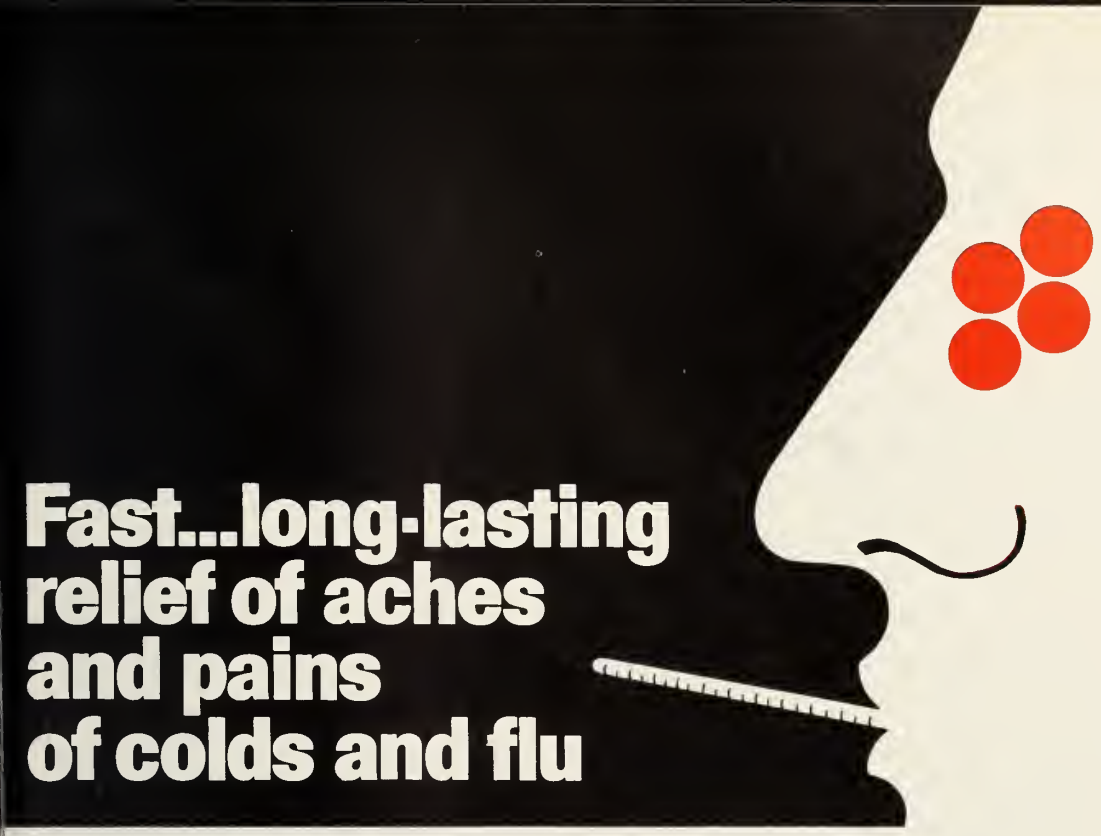
e. Either side can request a preliminary trial on the question of whether the statute of limitations has run out before the substance of a suit is tried.

6. One interesting recommendation is that the patient take out malpractice insurance. For example, an OB patient might secure insurance to cover an unfortunate result of treatment. Although at first thought, this might sound revolutionary, it is not much different from the concept of the flight insurance sold at airports.

7. Other suggested remedies include those of a statutory limitation on jury awards, that legislatures pass a firm statute of limitations regarding malpractice, and that administration of malpractice be placed in the hands of states (similar to that of Workmen's Compensation) with a scale of payments and damages.

8. A further recommendation is that OSMA conduct a series of malpractice workshops to provide guidelines for improving patient relations and preventing possible areas of negligence. This might be a step in the right direction. However, it seems likely that the physicians who may need help the most would not attend, and the physicians who need such assistance the least would attend. The experience of a particular physician may be very significant. Jason Crain, an insurance consultant to a number of hospitals and clinics in the Cleveland area, has been quoted as saying "one risk-prone doctor in 5,000 can cause a 25% increase in premiums."

9. The Ribicoff Sub-Committee Report indicates that the problem will grow to such proportions that the Federal Government may have to provide a solution. It might have to



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consider, for example, a re-insurance pool to which it would contribute.

As stated in the title, the upcoming number of claims, size of awards, and amount of the premiums for professional liability insurance, is uncertain. However, some relief may soon emerge. The AMA is conducting an intensive fact-finding survey to seek more economical ways of underwriting professional liability insurance and more effective techniques of averting or coping with malpractice problems. In studying alternative methods, AMA is seeking to determine whether it would be feasible for the AMA to sponsor, in cooperation with state medical societies and insurance carriers, a nationwide professional liability insurance program. At the 1969 Annual and Clinical Conventions, the House of Delegates directed that "urgent priority" be given to the search for solutions to professional liability problems.

One solace for the Ohio physician is that his colleagues in many other states are experiencing more serious situations. We can hope that their attempts to solve the problem will be successful and can thus be adopted for Ohio.

(Editor's Note: The reader may find it helpful to reread the article "The Malpractice Dilemma" by Donald L. Wentz, Vice-President of the Shelby Insurance Company, beginning on page 108 in the February, 1970, issue of *The Journal.*)

Ohioans Among Catastrophic Deaths in 1969

The catastrophic death toll in 1969 was somewhat over 1,300 — about the same as in 1968, but below the annual average for the past decade in the United States (excluding Alaska and Hawaii), according to statisticians of Metropolitan Life Insurance Company.

During 1969 there were eight major catastrophes, (a catastrophe is a disaster claiming 25 or more lives); in the aggregate they resulted in 542 deaths. Five of these disasters were natural catastrophes, the largest occurring on August 17 when a hurricane swept through Mississippi and Louisiana — killing about 200 persons. The four other natural disasters were the hurricane-caused flood which occurred in Virginia on August 20, taking 80 lives; the rain, floods, and subsequent mud slides in California late in January, causing 43 deaths; the tornadoes in northern Ohio on July 4 which killed 41; and the tornadoes which struck southern Mississippi on January 23, fatally injuring 32 persons.

Two of the disasters involved accidents in civil aviation: the collision of a scheduled plane and a small private airplane on September 9 near Indianapolis, which took 83 lives; and the crash of a scheduled plane into the Pacific near Los Angeles, on January 18, taking 38 lives. The other major catastrophe involved the collision of an oil barge and a freighter near New Orleans on April 6, resulting in the loss of 25 lives.

Most of the types of catastrophes — fires and explosions, motor vehicle, civil aviation, mines and quarries — were responsible for fewer deaths in 1969 than in 1968. However, the number fatally injured in natural catastrophes rose sharply, while deaths in military aviation increased slightly.

Metropolitan statisticians point out that natural accidents — hurricanes, floods, tornadoes, etc. — accounted for one third of the catastrophic deaths in 1969. Fires and explosions (mostly in private homes and apartments) and civil aviation each caused about one fifth of the total loss of life. Motor vehicle accidents were responsible for one sixth of all catastrophic fatalities, with military aviation contributing the majority of the remainder.

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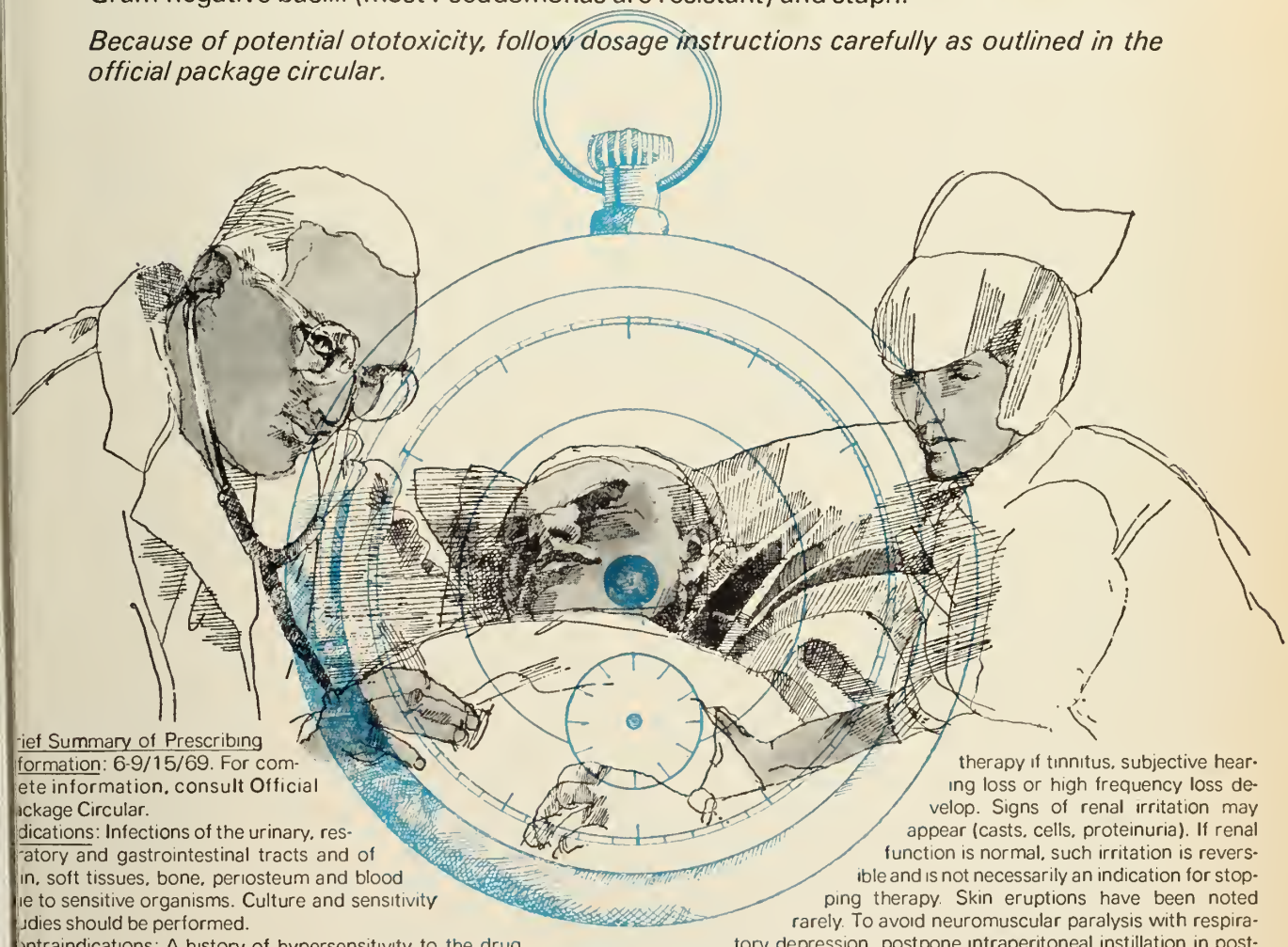
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Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.

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16	3.50	4.40
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Precautions: Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations.
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*Reports on file: Medical Research Department, Mead Johnson Laboratories, Evansville, Indiana 47721

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and we "Quote"

Abortion and Euthanasia—Contradictory (?) Philosophies

". . . We have developed, somehow, the philosophy that the taking of life before birth is a matter of no consequence, if the birth is a threat to either the mother or the child. At the same time, we have rejected the principle of euthanasia at the other end of life's span when to continue living may be anguish for the individual, a hardship for his family, and a waste to society. It is difficult to reconcile these two seemingly contradictory opinions. . . . Perhaps one of the reasons we have accepted abortion and rejected euthanasia is that the former appears to be a rather less complex problem than the latter. . . ."—Stanley Crosbie, M.D., *Rocky Mountain Medical Journal,* November, 1969.

Classic Illustration for the Communications Gap

"Just how do you communicate? That is really the question that must be answered. Just how can we get the word out to our 10,000 members on issues of major concern to medicine? . . .

"One of our members recently wrote in with a suggestion that there be a regular monthly column in *The Bulletin* on professional liability. Fine. But, he addressed this letter to the President of two years ago."—Ralph M. Milliken, M.D., President, Los Angeles County Medical Association.

Medical Responsibilities—Where Do They Stop?

"Care of patients, hospital administration, health programs, staying abreast of the advances in the social and scientific aspects of medicine, managing their own complicated affairs, taking the abuses of the bureaucrats and the news media, are enough to try doctors' souls, but be that as it may, do our responsibilities end with our own affairs? Does care of patients include participating in the affairs of our country? Certainly these affairs are vital to our public and connected with many of their ills. Is there a precedent for our participating in the affairs of our nation? With no intent to wave the flag or glorify the Constitution, we should remember that seven doctors were at the signing of the Declaration of Independence."—Lenox D. Baker, M.D., in the *Southern Medical Journal.*

Good Intentions and the New Morality

". . . . It is this quotation that forms the basis of my criticism of Mr. Wood (*Sex and the New Morality,* by Frederic C. Wood, Jr.) His intentions are noble, but good intentions can backfire. He is a mature man of superb intelligence, endowed with high ethical values and a keen sense of social responsibility, but how many youngsters share these attributes with him? A set of guidelines that will work for people like him may be unsuited to the young college coed who is floundering in a struggle with conflicting pressures coming in upon her from all sides. . . ."—Max Levin, M.D., New York, in *Current Medical Digest,* January, 1970.

Alcoholic Workers—Icebergs on the Industrial Sea

"The dimensions of on-the-job alcoholism are elusive because most drunks are able to conceal their problem. 'It's an iceberg, with the biggest part hidden from management,' says an official of Anchor Hocking Corp. of Lancaster, Ohio. Buckeye Steel, a Buckeye International Inc. subsidiary that discusses the problem more candidly than most companies, estimates that 18 percent of its employees have a drinking problem that affects the company. That rate is probably higher than average, because Buckeye studies have found that the rate tends to run high in the foundry industry, where the labor pinch is particularly acute.

"There's no question the problem is worsening. Officials at the National Council on Alcoholism estimate that alcoholism costs American employers $4 billion a year in lost time and ineffectiveness. That's up from an estimate of $1 billion five years ago, although officials now say that the 1964 estimate was too low.

" 'Alcoholism is more prevalent in industry than it was five years ago,' agrees J. J. Davis,



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Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Solerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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president of Esco Corp., a Portland, Ore. alloy steel foundry. 'It may be the result of greater affluence in that people have more money to buy booze. And they know employers can't fire them so readily in a tight labor market.' "—*The Wall Street Journal.*

Suggests Simplified System of Chemical Values

"We tried to compile a list of normal values of chemicals in blood and in other parts of the body, and we were at the same time defeated by the problem and can claim to have solved it. We found international units, Nelson-Somogyi units, U.S.P. units, and King-Armstrong units; and in addition, there were milliequivalents and milligrams percent and micrograms per hundred milliliters. . . . We suggest that units have become too important and too many, and that the patient may suffer if his doctor cannot remember hundreds of values when the laboratory is closed. Why not use 100 as the normal for everything? . . .—F. C. in the *Nebraska State Medical Journal.*

Differences—or Increasing Breadth of Outlook

"That there is wide variety of opinion and outlook of the (AMA) members is revealed each week in an ever-fascinating way in the pages of the *American Medical News,* under the heading LETTERS. One wonders, on reading it, if 'Association' is justified. From the size and frequency of the differences of opinion it seems more like dissociation.

"Let us cherish the difference! It is the cause of our increasing breadth of outlook. The man who holds a view opposed to your own may be a thorn in your side but he is also a great asset. We must have a wide variety of opinion—our success depends on it. . . ."—Carl B. Lechner, M.D., in *Pennsylvania Medicine, February,* 1970.

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You might also say that all interns aren't alike, either.





SPECIAL CONTRIBUTION

The Doctor Is a Patient

January 23, 1970

PERRY R. AYRES, M.D., EDITOR

Dear Dr. Ayres:

For years, I have been writing and lecturing on the healing power of faith, as an adjunct and supplement to scientific, medical, and surgical treatment. Now that I am slowly convalescing from a major abdominal operation, I have the leisure to reflect on this significant subject in the light of my own bitter experience.

There is no place like a hospital sickbed for thinking things through—about yourself, your personal life, and life in general. You learn that people are much better, much more human and humane on closer acquaintance. You also re-evaluate your world-view, your *Weltanschauung* during the long silent nights when sleep does not come even at the call of the "sleeping pill."

You wonder whether it was all worthwhile: this scrambling and striving, this insatiable craving for status and prestige. What matters most at this moment of pain and "dis-ease" is that many dear ones are worried and concerned. So many prayers, spoken and unspoken, have ascended to the Mercy Seat in your behalf. You have the comfort of knowing that you are not alone in this sickroom. The spirits of loving kinfolk and friends hover near you. What strength and solace come to you with that thought!

Your self-esteem may have sunk to a very low ebb because, as a sick man, ordered to do this or to take that, you are no longer the medical oracle to whom patients, family, and friends listened with rapt attention and respect. Now that you are on your back, Joe, you are really getting to know yourself, your powers, abilities, and limitations. You learn how much you can take with fortitude, patience, and resignation.

Along with the strength imparted by the prayers and good wishes of friends and family and the helpful presence of my dear wife, my own hope and trust in my eventual recovery has infused my mind and body with the vitalizing, energizing spiritual vitamins, without which healing and cure are out of the doctor's reach. Being aware of the prayers offered up in my behalf has been the means of alleviating my pains, of ameliorating my sufferings, of filling my soul with hope and confidence that the knowledge, skill, and kindliness of doctors and nurses will prevail against the pathologic malfunction and disharmony in some vital organ that was sapping my health and strength.

The operation, so far, has been highly successful, much to the amazement of my physicians who had anticipated a much slower progress in a patient of my advanced age. The major factors in this progressive recovery are the intangible, mysterious built-in forces which make healing and cure a true miracle. But let me stress as emphatically as I can that the surgeon's scalpel, guided by his highly trained mind and sensitive fingers, was the means of cutting the Gordian knot that was causing the serious obstruction which made me so sick. The surgeon did the cutting and the sewing up, but the miracle of healing was the work of mysterious and enigmatic forces manifesting a plan and purpose in life beyond our understanding.

In the good old days, diagnosis was usually a matter of the opinion, judgment, experience, intuition, and wisdom of the elderly physician. Doctors often disagreed and occasionally the patient got well through his own "wisdom of the body." Today, in this computer age, medical science has placed at the disposal of my physician-internist all the facts and data provided by the x-ray film, blood chemistry, and even the electronic isotope illuminating with its radiation the structure and metabolic function of the blood, tissue, and organ.

Certainly prayer helped, the love and concern all about me helped. Here science and faith work hand in hand. Sickness, mental or physical, is an evil. Slums, delinquency, crime, pollution, and violence are social evils. These personal and social evils must be traced to their sources. They must be studied and understood, in order that they may be prevented, and, if possible, cured or ameliorated. There is a sickness of the body-mind entity, and there is a sickness, a pollution, a poisoning of our social and economic environment in which, unfortunately, many of us are doomed to be born, to grow, and to live and die.

We must turn to faith, to the faith of our fathers, to pray for the wisdom, the courage, the strength, and the dedicated will to deal with these evils, individual and social, which we must seek to prevent and overcome. Else we perish.

With cordial regards,

(Signed) Joseph Krimsky, M.D.
Ormond Hotel
Ormond Beach, Florida 32074

Standards of Early American Medical Education

Donald E. Pitzer, Ph.D.

THE NINETEENTH CENTURY has been called "the beginning of the Golden Age of Medicine."[1] The years following 1840 evidenced a rapid sequence of medical discoveries, but they were almost without exception of European origin, not American. Louis Pasteur and Robert Koch pioneered in bacteriology. Joseph Lister made the first attempts at performing antiseptic surgical operations. Gregor Mendel set down the laws of heredity. Victor Horsley initiated operations upon the central nervous system and Wilhelm Roentgen discovered x-rays. Why should it be that while Europe was the fountainhead of nineteenth and early twentieth century medicine, the United States should witness such a dearth of medical advance? What should justify Harvard President Charles W. Eliot's statement in 1872 that "it is fearful to think of the ignorance and incompetence of most American doctors who have graduated at American schools. They poison, maim, and do men to death in various ways, and are unable to save life or preserve health"?[2] Or why, as late as 1891, could a European assert with validity that it is "not a matter of surprise that American degrees in medicine should be regarded with distrust in Europe, and placed in the same category as those amiable but meaningless distinctions which are conferred on people dancing the cotillion"?[2] Answers to these questions can be found in the effects of United States territorial expansion upon its medical standards and education.

The Author

• **Dr. Pitzer, formerly of Columbus, is Assistant Professor of History, and Chairman of the History Department, Indiana State University at Evansville.**

Proprietary Medical Schools

The five earliest medical schools in the United States, founded between 1764 and 1798, were based soundly upon the European clinical and university types.[3] Associated with hospitals and universities, these schools combined the salutary qualities of clinical instruction, elevated intellectual standards, and economic and geographic stability. However, this progressive genesis was overshadowed by the rapid settlement of the frontier after 1800, which encouraged the development of a uniquely American means of producing physicians. The expanding region created a growing population with an acute need for medical services, but its meager public schools did not provide well-trained students to enter eastern medical schools, and its primitive conditions did not assure practitioners a reliable income. The unfortunate result was the mushrooming of proprietary medical schools with minimal entrance and graduation requirements but capable of producing the quantity, if not the quality, of doctors demanded by the public. It immediately became apparent that such commercial schools, divorced from hospitals and universities, could be operated at a handsome profit. By 1840 the United States had 76 medical schools,[4] mostly of the proprietary variety in which "loose and shifting bands of practicing physicians, calling themselves a faculty, tried to impart, chiefly by lectures, to heterogeneous, uneducated groups of students the empirical knowledge—sound and unsound—which they themselves possessed."[5] By 1910 the United States and Canada had had the dubious honor of harboring 457 institutions intent upon creating doctors. Fifty of these schools were stillborn and

Submitted August 13, 1969.

many were short-lived; about 20 were located at Cincinnati, Ohio alone.[4]

Equipment and Facilities

Since proprietary medical schools were the dominant form of American medical education from the early 1800's through 1910, the standards of these institutions ironically were representative of the medical standards in the United States during "the beginning of the Golden Age of Medicine" in Europe. Proprietary schools differed widely in the extent and quality of education which they offered, but the typical pattern was similar in all. Since little else than teachers and students were required to found commercial schools, they sprang up in every conceivable location. Further, "these enterprises—for the most part they can be called schools or institutions only by courtesy—were frequently set up regardless of opportunity or need."[4] The equipment of the schools was usually limited to a cheaply rented hall, several crude benches, a skeleton supplied by an occasional dissection, "and a box of old bones."[4] Laboratory equipment was almost nonexistent in all medical schools in the country. The stethoscope had been in use in Europe for 30 years before it was mentioned in the Harvard Medical School catalogue in 1868. The Harvard catalogue did not mention the use of a microscope there until 1869.[4] Schools frequently overstated their facilities when advertising for students. The Halifax Medical College boasted that "first-class laboratory accommodation is provided for histology, bacteriology and practical pathology." Upon investigation the college was found to have "one utterly wretched room . . . provided for all three." The Medical Department of the University of Chattanooga advertised a "generous supply of the best microscopes" available to its students. It actually had *one*.[4]

In place of equipment and facilities, the commercial schools had one primary substitute—didactic lectures. Lectures, which might have been helpful in a well balanced lecture-clinical curriculum, became the entire program. In most schools, they were combined with a small amount of instruction in anatomy. There was little or no student-teacher or student-patient contact. By merely attending the lectures in a huge, poorly lighted amphitheater and possibly passing a written examination, the student could gain his "M.D." Before the age of state health boards, the student's diploma or degree was his license to practice. Having had no clinical instruction, many of these newly made doctors used their first patients as guinea pigs until they could gain some practical experience. Most of the commercial schools began with a single year's course of instruction, from October to spring, leading to a diploma and the right to "hang out a shingle." This plan was particularly profitable since every class was a senior class and, therefore, the lectures could be given year after year without addition or revision. Furthermore, the numerous new physicians being produced were in constant need of postgraduate advice in cases, thus furnishing additional remuneration for obliging faculty members. The one-year course plan continued in vogue at some schools even beyond 1900.[4] Another malady of the curriculum was the absence of a graded program. This fact nullified to some extent the effectiveness of the two-year course where it was started. The fallacy of this arrangement was that "the student had two chances to hear one set of lectures—and for the privilege paid two sets of fees."[4]

Resurrectionism

Securing specimens for autopsies and general dissecting was a constant problem in that era. The need for anatomical material was increasing, but the legal sources for it were few. The resurrectionists who often supplied cadavers did much to sour public opinion against medical research. When the Medical College of Ohio, the first in the state, was opened by Dr. Daniel Drake in Cincinnati in 1820, the Queen City began experiencing the activities of the workers in this questionable trade.[6] One of the most renowned instances of grave robbing in the United States occurred in 1878 in connection with this school when the body of John Scott Harrison, son of William Henry Harrison and father of Benjamin Harrison, disappeared. After an intensive search, the corpse was discovered at the Medical College of Ohio suspended by a rope which was attached to a windlass in the chute which was used to hoist bodies up to the dissecting room.[7] Such scandals served to discredit the work being done by sincere medical researchers and students in many sections of the nation. The conditions of facilities for dissecting, where they existed at all, were often repulsive. As late as 1910 it was reported that "dissecting-rooms are indeed found, but the conditions in these defy description. The smell is intolerable; the cadavers now putrid, . . . again, dry as tanned leather."[4]

The Commercial Aspect

The commercial character of the medical schools also became a perpetual cause for internal dissent among the faculties. Since these schools had no vital link with universities, instructors could be hired or fired as the personal desires of the managers dictated. During this time, most of the former university medical schools (to their own detriment) gained their autonomy and fell into the pitfalls of the proprietary system. "Chairs" in

these schools became valuable pieces of property which could bring sizable rewards. Sudden and violent feuds frequently divided faculties. But such schisms rarely resulted in the closing of a school. Usually, they were only the occasion for the birth of new ones. If Daniel Drake was the creative force of the Medical College of Ohio in its earliest days, he also had his share in the internal troubles that beset that school. Drake held to high professional ideals and was extremely sensitive to criticism. As a result, he left the College, returned, and left again. Drake intermittently denounced the school publicly and tried to start new ones to rival it. He eventually founded several schools and filled 11 different chairs at Philadelphia, Lexington, Louisville, Cincinnati, and Oxford. The Medical College of Ohio entered a more tranquil and useful stage, with the coming of the Civil War, as the precursor of the University of Cincinnati Medical School.[4]

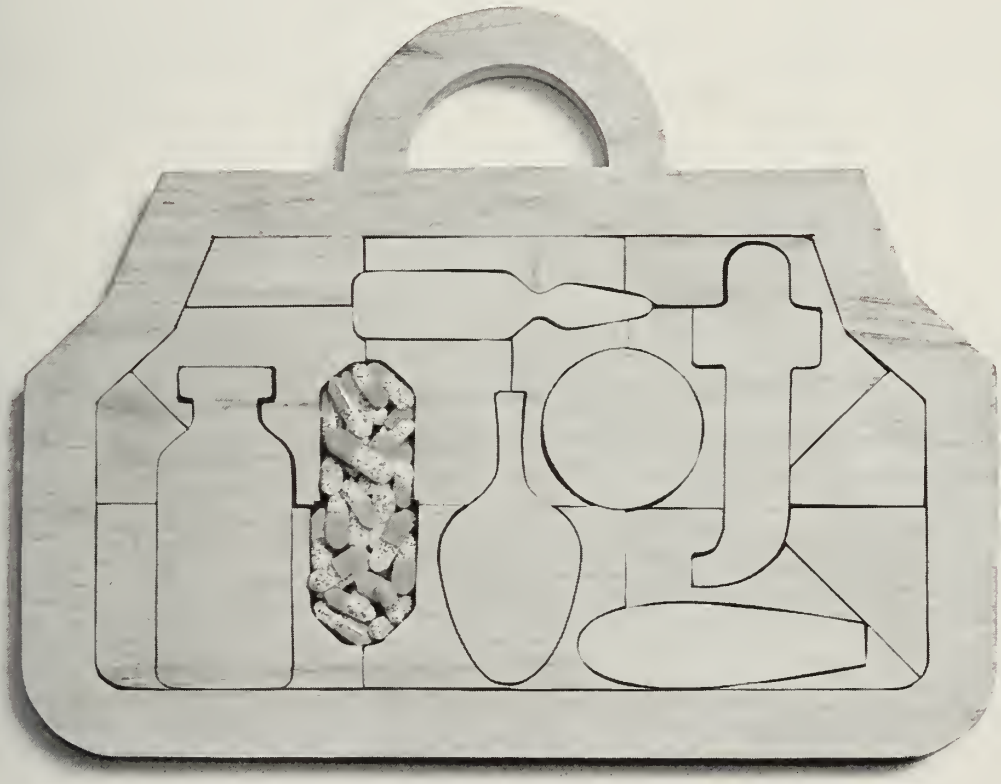
Obstacles to Reform

In the second half of the nineteenth century, an attempt to resist the inertia of this lowest ebb of American medical education and to start a trend toward rising standards gradually gained public support and eventually made its reforms effective through the cooperation of state legislatures. Many obstacles, however, lay in the path of such a reformation. Among the schools themselves, strict competition for students served as an effective deterrent to the raising of entrance requirements decade after decade. Any effort to make the course more demanding was likely to produce an exodus of students to a nearby competing school with lower standards. By 1900, the medical schools could be divided into four classes with regard to their entrance requirements. The first class required no formal education or else pretended to hold "equivalents" to such education as the condition for entrance. The second class of medical institutions held to high school education or its "equivalent" for admission. In the third class were those few medical colleges which required two years of undergraduate college work as a prerequisite to medical school. Standing alone above these three divisions was the Johns Hopkins Medical School with its stipulation of a baccalaureate degree for matriculation. In reality, however, almost any partially literate person could earn a medical degree somewhere in America before the end of the century.

Apathetic public opinion concerning medical standards and education was another nearly insurmountable problem to the raising of American medical values. Where public voices were heard on the subject, they usually said that the need for doctors was so pressing that *more* doctors was of greater importance than *higher* standards. Many argued that higher entrance requirements would restrict the attendance of the "poor boy" who was not privileged to graduate from high school. Others felt that college trained doctors would not condescend to fill the urgent needs of the small towns, where monetary returns might be unattractive. Such arguments were not effectively rebutted until the research for the monumental Flexner Report in 1910 began to uncover the true facts of the case. The Flexner Report bluntly concluded that standards must be set to promote "health, physical vigor, and happiness" regardless of who might be restricted from becoming a physician. The well-being of society was at stake. This report suggested that the "poor boy" be aided to an adequate preliminary education rather than to inflict society with the peril of ill-prepared physicians. It asserted that "low entrance requirements flourish, . . . for the benefit of the poor schools, not of the poor boy." This study also showed that the fees in creditable medical schools were not appreciably higher than in schools accepting inferior educational preparation for admission. It was demonstrated that two years of college plus four years of medical school at Ann Arbor in 1909 could be acquired for $1,466, while $1,420 was charged for merely four years of medical school in Baltimore, Philadelphia, and Chicago. Even the contention that better trained physicians would not migrate to the smaller towns was shown to be unsound when Johns Hopkins graduates were found scattered throughout the nation in both large and small towns by 1909.[4] Money alone was not the chief consideration in the location of doctors.

Role of Medical Societies

Local and national medical societies were among the most important factors in creating an atmosphere in which medical reform could occur. During the early decades of the nineteenth century, numerous local medical societies were founded. Then, in 1846, the New York State Medical Society proposed the meeting of a "National Convention of delegates from medical societies and colleges of the whole Union."[3] At the 1847 National Convention, the name American Medical Association was adopted, and from its inception this organization was committed to expending effort to secure a higher American medical ethic and practice. This inevitably meant agitation to improve medical school standards, methods, and facilities. The medical schools themselves began to sense that the reform tides were rising. In 1876, twenty-two of them banned together to form the Medical College Association to promote the common good.[8] Although this organization was rather inert from its inception and became completely extinct in 1882, a uniting force remained among



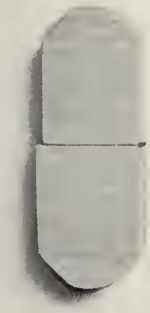
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the medical institutions and brought them together again in 1891 as the Association of American Medical Colleges to carry on the work of the former organization.[9] After 1891 this group set minimum standards for all schools seeking membership. This served the general purpose of standardizing as well as elevating the prevailing conditions in the member institutions. By 1896, fifty-five of the 155 extant medical schools in the United States had become members of the Association.[8] The relatively high percentage of member schools belied the rather lax requirements for membership, but it was a self-motivated beginning toward upgrading educational standards.

Licensing Requirements

It finally was recognized, however, that legislation was the only effective and permanent basis upon which to build better medical standards. The American Medical Association held to the propositions "that young men received as students of medicine would have acquired a suitable preliminary education" and "that a uniform elevated standard of requirements for the degree M.D. should be adopted by all the medical schools in the United States."[5] For this purpose, in 1877, it passed a resolution urging the president and secretary of the Association to continue an appeal year after year to the governor in every state until state boards of health should be established.[3] But progress was very slow. There existed few, if any, legal precedents from which to launch this late nineteenth century crusade for state medical boards or on which to found the new laws providing for the state licensing of physicians. Since no licensing whatever was required in the eighteenth century, many men who had served apprenticeships under local doctors declared themselves physicians without any formal training whatsoever. The earliest schools themselves granted M.B. and M.D. degrees which were used in lieu of licenses.[10] By the early 1800's, membership in local medical societies was usually recognized as sufficient proof of medical standing to warrant one's medical practice.[11] Later, diplomas from virtually any medical school were regarded as fulfilling the requirements for entrance into the profession. This arrangement encouraged the flourishing of commercial medical schools by mid-century.

It was in this setting that the progressive medical colleges, societies, and individual physicians began the difficult task of securing state legislation to raise the quality of practitioners by stringent licensing examinations. The only effective agency for such action would be state medical boards, but it was not easy to persuade state legislatures of the need for them. One contributor to *The Journal of the American Medical Association* in 1883 noted that one obstacle blocking laws on the regulation of medical practice was the "prejudice of members of Legislatures who believe that they themselves were occasionally benefitted by prescriptions that were not wholly scientific in character."[12] Unflagging reform effort plus an increasingly enlightened public opinion upon the questions of sanitary improvements and the quality of education of those being permitted to practice medicine brought 19 state medical boards into being by 1878.[3] By 1891, there were twenty-six.[13] Pennsylvania had set its license regulation at a diploma from a medical school in 1881. In 1883 Michigan did the same, followed by Indiana in 1885. At the 1887 session of the Illinois legislature, the future medical profession there was limited to those having a college diploma or passing an examination by the state board of health. In Kentucky, a requirement of ten years of practice or a diploma from a medical school was set for licensing in 1890.[13]

(To be concluded in May issue.)



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The Editor's Page



And Away We Go — With the Self-Evaluation Quiz

Peer-evaluation and self-evaluation by and for physicians are subjects prominent in medical news these days. Mechanisms for accomplishing such evaluation are difficult to initiate, but the rewards for individual practitioners should be great, if the evaluations are properly carried out. Peer-evaluation is being investigated very carefully and thoroughly by the American Medical Association and by the Ohio State Medical Association. We are concerned here with self-evaluation.

For some time now, we have been pondering ways to provide some means of self-evaluation for Ohio physicians. The very comprehensive examinations prepared and distributed to interested Fellows and Associates by the American College of Physicians provide an excellent model, and the College has since published many of these questions (and their answers) in the *Annals of Internal Medicine*. We have hoped to provide a similar series of questions for our readers.

The source of suitable questions and answers was our stumbling block until a few months ago, when it occurred to us to turn to the four Schools of Medicine in Ohio. After obtaining the permission of the Deans of two of the Schools, we wrote to representatives of their clinical departments asking that they furnish us a supply of multiple choice questions (with answers and supporting explanations or references) selected from examinations prepared for their third- and fourth-year students. Toledo, of course, has no third- or fourth-year classes as yet, and Case Western Reserve University informed us they use examinations prepared by the National Board of Medical Examiners. However, two departments at Ohio State University and one at University of Cincinnati have supplied us with a sufficient number of questions that we decided to proceed. We hope that the folks at O.S.U. and the University of Cincinnati will keep us supplied, if we prod them often enough.

So, away we go with the Ohio State Medical Journal Self-Evaluation Quiz! Questions will be found at the end of some Clinical and Scientific articles, and the answers will be found elsewhere. Give it a try.

We would like to know what our readers think of this new feature, we would welcome letters of comment upon the subjects represented by the questions, we shall be happy to consider questions and answers from any other source, and we hope our readers in Columbus and Cincinnati will encourage the faculties of their local universities to keep the questions coming. The better and the more numerous the questions, the better the quiz!

(See page 393)


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Clinical & Scientific Features

Volume 66 April, 1970 Number 4

Effects of Dietary Glucose and Cholesterol on Atherosclerosis, Aortic Lipids, and Serum Lipid and Insulin Levels in Rabbits

P. W. Flanigan, M.D., J. N. Herrold, M.D., and M. Tzagournis, M.D.

CHOLESTEROL FEEDING has induced experimental atherosclerosis in a variety of animals. Other factors, including diabetes mellitus and hypertriglyceridemia, have also been associated with atherosclerosis. Duff and McMillan[1] reported that the severity of aortic atherosclerosis in alloxan-diabetic rabbits was considerably less than that observed in nondiabetic control animals fed a comparable diet. Many of the diabetic animals had no atherosclerosis in spite of marked hypercholesterolemia in response to cholesterol feeding. Other studies confirmed these findings and showed that insulin treatment made the diabetic animals as susceptible to cholesterol-induced atherosclerosis as the nondiabetic animals.[2-4]

It was reported that young patients with proven coronary heart disease had a high frequency of abnormal glucose tolerance and glucose-induced insulin response.[5] The insulin abnormalities were characterized by elevated levels of immunoreactive insulin and/or delayed secretion, peaking at the 2- or 3-hour interval. Furthermore, the mean insulin concentration of the coronary patients during a 3-hour glucose tolerance test was significantly higher than that of comparable control subjects without coronary disease.

These findings suggest that insulin may play a major role in atherogenesis. The lipogenic effects of insulin on hepatic and fat cells are well known.[6] It is also known that the arterial wall has the ability to synthesize lipids[7,9] and that insulin can stimulate lipogenesis in arterial tissue both *in vitro* and *in vivo*.[10, 11] Therefore, it is possible

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Submitted November 18, 1969.

that insulin may promote lipid accumulation and subsequent plaque formation by increasing lipid synthesis or by decreasing lipid degradation in the intima.

In this report the effects of dietary cholesterol and glucose alone, and in combination, were studied. Glucose was used because serum insulin levels after a glucose meal are higher than after starch meals.[12] The results suggest that dietary cholesterol causes increased serum and aortic cholesterol concentrations, while glucose feeding enhances aortic triglyceride deposition.

Methods and Materials

Sixteen male New Zealand albino rabbits weighing 3.0 to 3.3 kilograms were used in the experiment. They were kept indoors in separate cages. After approximately four weeks on Purina® laboratory rabbit chow, they were randomly assigned to four groups with diets as follows:

Group A—regular chow and tap water
Group B—regular chow plus 25 grams of glucose in water per animal per day
Group C—0.2 percent cholesterol concentration in the chow plus 25 grams of glucose in water per animal per day
Group D—0.2 percent cholesterol chow plus tap water

The rabbits were given weighed portions of chow, but food was available at all times. An average intake was calculated every 7 to 12 days. Water was allowed ad lib., but the animals on glucose were not given tap water until they had consumed the glucose water. At 0, 3, 9, 11, 14, and 16 weeks each animal was weighed, examined, and 7 to 10 cc of whole blood was drawn from an ear vein during the early afternoon. Sera were frozen until analyses could be made for glucose,[13] immunoreactive insulin,[14] cholesterol,[15] and triglyceride[16] concentrations.

At the end of 16 weeks, the rabbits were sedated with pentobarbital and killed by air embolus. The thoracic aorta was removed promptly after death, stripped of adventitial fat, and opened longitudinally for visual grading of atherosclerosis. The intimal surfaces were classified by two observers into grades 0, 1, 2, 3, and 4 atherosclerosis according to the method of McMillan and coworkers.[17] Specimens of the aorta were taken one centimeter distal to the origin of the cranial vessels. The intimal tissue was removed with fine forceps carefully avoiding contamination by adventitial fat. It was then frozen until it was homogenized in a glass tissue grinder and the lipids extracted using chloroform-methanol.[18] Aortic cholesterol and triglyceride concentrations were determined after evaporation of the extraction solvent.

The specimens were fixed in formalin, and frozen sections were stained for lipid with Oil-Red—0. Two observers independently graded the lesions with the light microscope as follows:

0 no intimal fat
1 minimal intimal fat
2 moderate intimal fat
3 marked intimal fat
4 plaques, minimal in number and degree
5 plaques, moderate to severe in number and degree

Group means, standard errors, and t—tests were computed and two tailed significance levels were determined using the standard "Student" distribution.

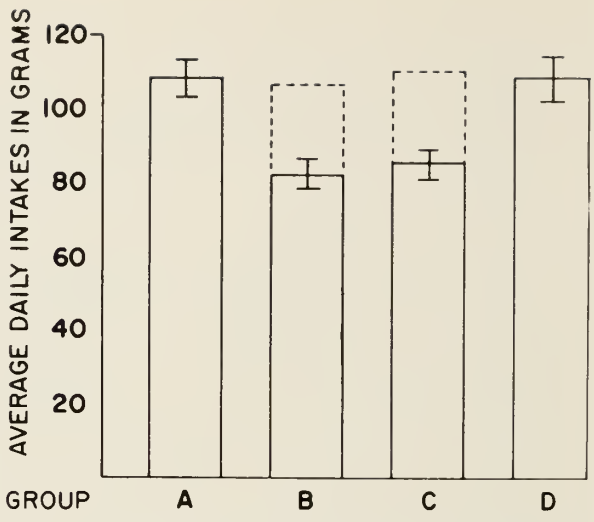


Fig. 1. Average daily intake (± S.E.) per animal by groups. Solid lines indicate chow intake, dotted lines include glucose intake.

Results

Dietary intake. The average daily intake was quite similar for the four groups (Fig. 1). The average daily chow or chow plus glucose intake ranged between 107 and 110 grams per animal per day for each group, making their diets approximately isocaloric. However, of the two groups receiving cholesterol, the diet of Group C differed in cholesterol content from Group D because of the lesser amount of adulterated chow eaten.

The mean weights of the groups showed no significant losses or gains during the experiment. The general condition of the animals was good throughout the study.

Serum concentrations of glucose, insulin, cholesterol, and triglycerides. Table 1 summarizes the mean values obtained at each interval during the study. The overall mean values of the various determinations in each group are tabulated in the last column.

The mean overall serum cholesterol concen-

tration was 241±34 (S.E.) and 297±46 mg per 100 ml in groups C and D, significantly greater ($P<0.001$) than in the noncholesterol-fed groups. The serum cholesterol increased significantly ($P<0.05$) by the third week in both groups C and D. Peak levels were reached between the ninth and 14th weeks with a return toward normal by the 16th week. This pattern is common for rabbits ingesting cholesterol.[19]

The serum triglyceride levels of Group C were significantly greater ($P<0.05$) than those of the control group. The failure of Group B or D to develop hypertriglyceridemia makes it difficult to attribute the rise in Group C to either glucose or cholesterol alone. Possibly these two dietary components work synergistically to elevate circulating triglycerides.

Group C had a slight but insignificant rise in serum insulin levels. The fact that hyperinsulinism was not observed in the glucose-fed groups does not rule out the possibility that the glucose ingestion caused greater insulin secretion than the chow alone. Insulin levels are characteristically variable and in this experiment samples were taken only in the early afternoon.

The serum glucose concentrations showed no significant changes during the experiment.

Atherosclerosis. Grossly, atherosclerotic involvement of the intima was seen only in the cholesterol-fed groups. Table 2 summarizes the graded gross lesions at the time of autopsy. Two of the four animals in Group C had elevated pearl-colored plaques, while the others had no visible lesions. The most extensive lesions were found in one of the rabbits fed cholesterol plus glucose.

The microscopic lesions likewise were greatest in Groups C and D although Group B animals also demonstrated microscopic lipid accumulation in the intima (Fig. 2). In general, the severity of atherosclerosis in the two cholesterol-fed groups was similar.

Aortic lipids. The triglyceride concentration in the intima was significantly elevated ($P<0.05$) in the glucose-fed Group B (Fig. 3). Aortic cholesterol levels were slightly elevated in Groups C and D (Fig. 4). Glucose plus cholesterol feeding in Group C seemed to be associated with less aortic cholesterol than in those animals fed cholesterol without glucose. The different chow intakes produced by adding glucose to the water resulted in Group C ingesting 19 grams of cholesterol per animal while Group D ingested 24 grams per animal. The ratios of ingested cholesterol to aortic cholesterol are almost equal for both groups, indicating that the difference observed may be

TABLE 1. Mean Serum Concentrations of Cholesterol (mg per 100 ml), Triglycerides (mg per 100 ml), Insulin (uU per 100 ml), and Glucose (mg per 100 ml)

Group		Week						Overall Mean Values While On Diet
		0	3	9	11	14	16	
A	Cholesterol	52±5	37±5	24±3	22±5	22±5	34±11	34±4
	Triglycerides	43±8	98±18	56±14	55±12	55±12	57±13	62±7
	Insulin	11±3	28±7	15±5	25±17	9±1	9±1	19±4
	Glucose	126±7	139±3	128±5	134±3	134±3	116±7	129±3
B	Cholesterol	31±4	34±4	31±6	23±1	63±14	41±11	38±5
	Triglycerides	42±8	87±11	55±24	114±27	42±8	114±11	82±11
	Insulin	20±12	24±9	8±0	56±48	13±3	21±8	26±10
	Glucose	141±7	136±16	118±3	129±4	140±11	112±2	127±4
C	Cholesterol	47±6	119±20**	818±78**	272±76**	348±98**	148±6*	241±34***
	Triglycerides	53±8	70±11	182±69	101±31	102±11*	108±15*	112±16*
	Insulin	47±27	21±6	56±22	65±45	104±55	135±92	74±23
	Glucose	135±4	132±4	125±9	127±3	149±13	147±13	136±4
D	Cholesterol	36±3	215±17***	458±104**	417±107*	248±112	144±79	297±46***
	Triglycerides	57±16	76±39	68±31	102±46	80±35	131±55	91±18
	Insulin	46±20	19±5	30±10	71±43	15±4	13±4	30±9
	Glucose	138±3	129±8	101±10	112±11	132±6	135±3	122±4

* $P<0.05$
** $P<0.01$
*** $P<0.001$

Mean group values are compared with the initial results during each period. The overall mean values (last column) of each experimental group are compared with control group A.

directly related to the amount of cholesterol consumed.

Figure 5 indicates that those animals ingesting glucose (Groups B and C) had significantly higher aortic triglycerides than those that did not take glucose (Groups A and D). There was no significant variation of aortic triglycerides among the animals fed cholesterol (Groups C and D) or those not fed cholesterol (Groups A and B).

Discussion

Lipid accumulation occurring mainly, but not entirely, in the intima seems to be a consistent early change in the development of the atherosclerotic lesion.[20] It is reasonable to assume that lipid accumulation can occur either by excessive filtration of circulating lipids into the arterial wall or by excessive synthesis of lipids by arterial tissue.

The action of insulin as a lipogenic agent as well as an inhibitor of lipolysis is well known. Lipogenesis requires concomitant glucose metabolism in order to proceed at an appreciable rate. The synthesis of both triglyceride and cholesterol requires reduced diphosphopyridine nucleotide (DPNH) and reduced triphosphopyridine nucleotide (TPNH) which are derived from the Embden-Meyerhof and the hexose-mono-phosphate pathways. Thus, availability of insulin and glucose are prerequisites for lipid synthesis. That this action of insulin in intimal cells is, in fact, occurring is suggested by several recent studies.[10, 11]

In human atherosclerosis there is increasing evidence that hyperglycemia and hypertriglyceridemia must share with hypercholesterolemia the role of important associated metabolic factors in the development of lesions.[12-24] The results of this report in which the acute changes occuring in the sera and aortas of rabbits were studied, suggest that hypercholesterolemia as well as other metabolic phenomena may promote early lipid accumulation in the aortas of animals. A relatively low concentration of dietary cholesterol with or without glucose was associated with hypercholesterolemia, cholesterol accumulation in the intima, and early gross atherosclerotic lesions. On the other hand, glucose feeding resulted in a relatively high concentration of triglycerides in the aortic intima and microscopically evident lipid accumulations. It is possible that these two lipids synergistically accelerate the rate of atherogenesis in arterial tissue.

The increased triglyceride concentration in the intima could have resulted from excessive filtration of circulating lipids into the intima or by increased synthesis in arterial tissue exposed to glucose induced hyperinsulinism. More insulin is secreted in response to feeding of simple sugars

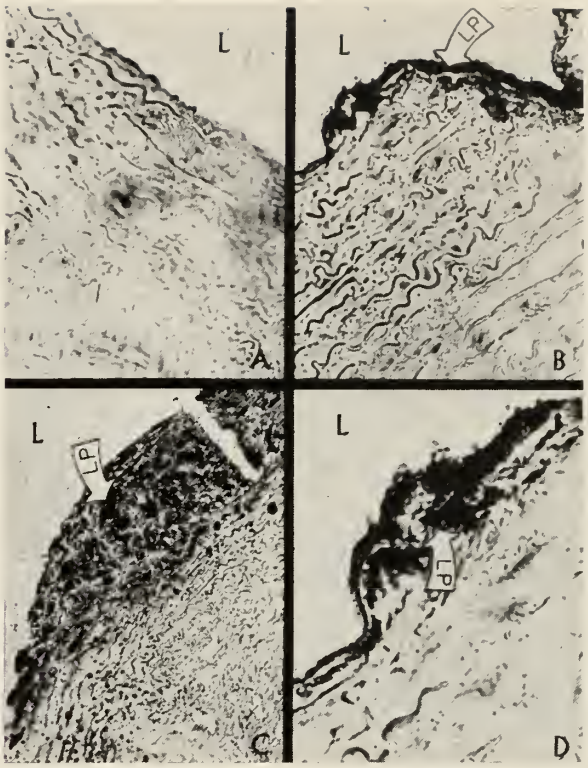


Fig. 2. The lumen of the aorta is designated L and the lipid in the intima LP. (A) Aorta, grade 0, from a rabbit in Group A, no demonstrable lipid deposition, X 1190. (B) Aorta, grade 2, from a rabbit in Group B. Lipid particles appear as black densities in the intima with Oil-Red-O stain, X 1190. (C) Aorta, grade 5, from a rabbit in Group C. Part of a large atheromatous plaque containing much lipid-staining material, X 170. (D) Aorta, grade 3, from a rabbit in Group D. Marked intimal infiltration with black lipid-stained particles.

Table 2. Gross and Microscopic Pathology of the Thoracic Aorta

Group	Gross Observations	Animal	Grade	
			Gross	Microscopic
A	4 animals with no lesions	1	0	0
		2	0	1
		3	0	1
		4	0	0-1
B	4 animals with no lesions	5	0	1
		6	0	2
		7	0	1
		8	0	1
C	2 animals with no lesions	9	0	2-3
		10	0	3
	1 animal with lesions in proximal 5 cm	11	2	4
	1 animal with lesions in proximal 2 cm	12	1	3
		13	1	4
D	1 animal with no lesions	14	0	-
	3 animals with lesions in proximal 2 cm	15	1	2-3
		16	1	3

such as glucose or sucrose than to a calorically equal amount of starch.[12] Increased insulin levels in combination with sufficient glucose substrate facilitate hepatic triglyceride synthesis and subsequent hypertriglyceridemia.[25] However, since hypertriglyceridemia could not be consistently demonstrated in the glucose-fed rabbits, increased lipid synthesis or decreased lipolysis of triglycerides in the intima itself could also account for the accumulation observed.

Further studies are necessary to determine if more chronic exposure to dietary glucose would result in enhancement of the atherosclerotic process. Investigation should also continue to determine what role, if any, accumulation of triglyceride plays in establishment of the atherosclerotic lesion

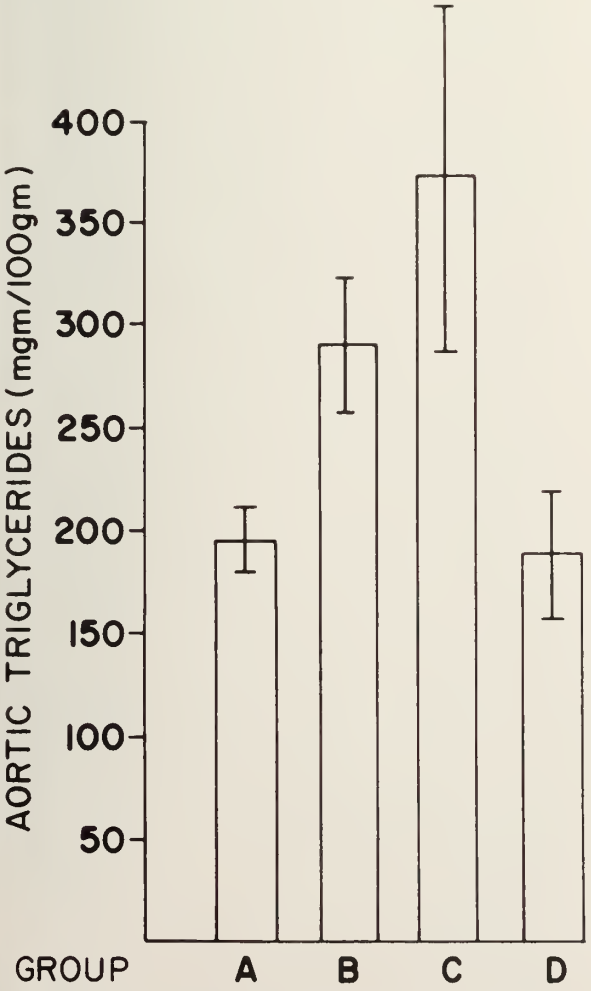


FIG. 3. Average aortic triglycerides (± S.E.) in milligrams per 100 grams of tissue. Group B is significantly greater than Group A ($P<0.05$).

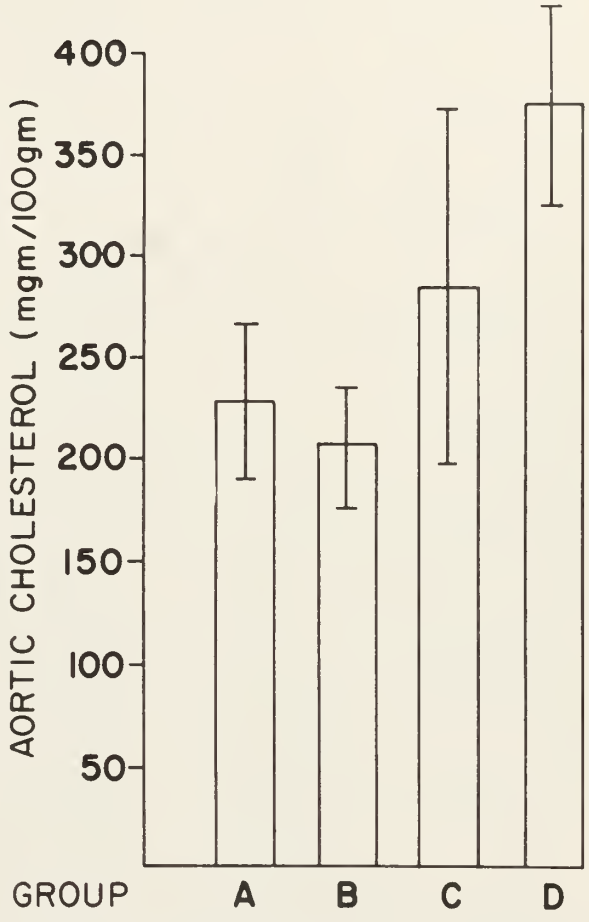


FIG. 4. Average aortic cholesterol (± S.E.) in milligrams per 100 grams of tissue.

or in the acceleration of cholesterol-induced atherogenesis.

Summary

The effects of small amounts of dietary cholesterol and glucose on early atherosclerosis were studied in rabbits. Serum concentrations of glucose and insulin in the special diet rabbits were not significantly different from those in the controls. Animals fed cholesterol demonstrated an elevation in their serum cholesterol levels, while those receiving glucose plus cholesterol showed a significant rise in serum triglycerides as well. Gross atherosclerotic involvement of the intima was only seen in the cholesterol-fed groups. Microscopic lipid accumulation in the intima was present in the glucose-fed groups, however, some lipid was also seen in control animals eating regular chow.

The results of this report suggest that triglyceride accumulation in the intima is enhanced by the simple sugar, glucose. It is possible

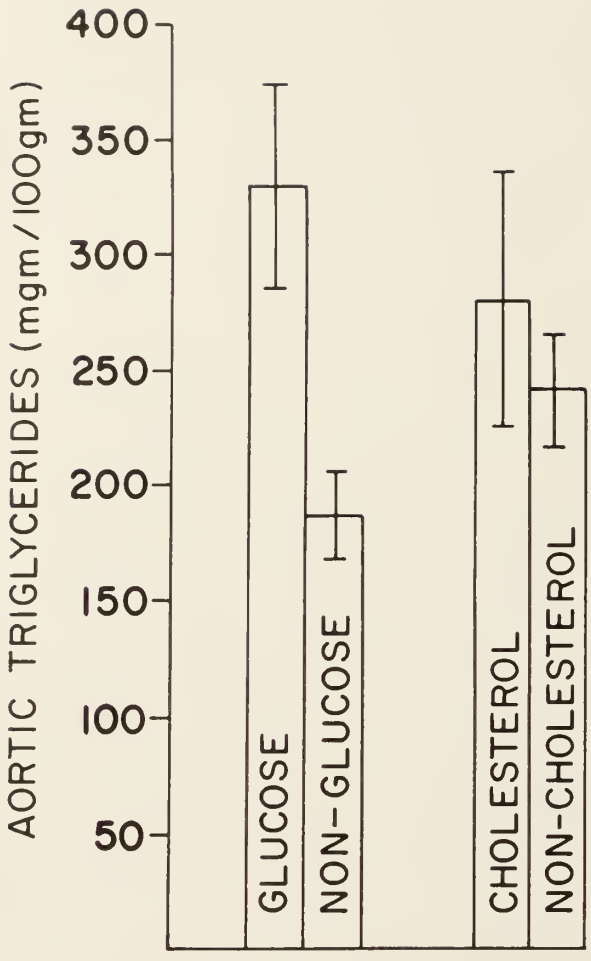


FIG. 5. Aortic triglyceride on the basis of diet. Glucose fed animals had significant triglyceride elevation ($P<0.05$) as compared to those not fed glucose.

that increased lipid concentrations in the intima play a role in the establishment of the atherosclerotic lesion and that hypercholesterolemia and hypertriglyceridemia may both be important in atherogenesis.

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Treatment Errors in Acute Osteomyelitis

Thomas H. Mallory, M.D., Thomas Meyer, M.D., and Edward J. Eyring, M.D.

ACUTE OSTEOMYELITIS can be successfully managed by proper initial treatment.[5] Progression of acute to chronic osteomyelitis may be attributed to inadequate therapy, especially in cases involving organisms that produce penicillinase.[9] There are adequate antibiotics available to control successfully the commonly encountered pathogens responsible for osteomyelitis.[11] It is, therefore, not so much a problem of resistant organisms as it is a selection of the proper antibiotic or a combination of antibiotics that are effective.[1,8] Management of acute osteomyelitis beomes a matter of early diagnosis followed by early treatment with adequate doses of the proper antibiotics.

Fifty cases of acute osteomyelitis were reviewed at the Children's Hospital, Columbus, Ohio, between 1955 and 1960. Penicillinase-producing organisms were an important causative agent. The importance of early diagnosis and the early treatment with antibiotics effective against penicillinase-producing organisms were stressed.

As a follow-up study, an additional 50 cases were reviewed, making an inclusive study of 100 cases of acute osteomyelitis treated at The Children's Hospital, Columbus, Ohio, between 1955 and 1965. Established criteria for the review included otherwise well children that became febrile with a swollen, painful extremity. In the course of the illness, there was roentgenographic evidence of osteomyelitis which included obliteration of soft tissue lines, periosteal reaction, or bone resorption. Attempts to isolate the causative agent were made by blood cultures and by needle aspiration of the involved area. Supportive measures such as blood transfusions, splints, and analgesics were used as indicated. No child had surgical drainage during the initial episode. Resolved cases had no further recurrence following the initial episode. Unresolved cases relapsed into repeated episodes of pain, fever, and swelling with progression to chronic osteomyelitis.

In 37 of the 100 cases reviewed, no organism could be isolated. All of these cases resolved following the initial episode. Their management had consisted of oral and parenteral penicillin given in variable amounts for a random period of time. In 63 cases, causative agents were identified, of which 56 were *Staphylococcus aureus coagulase positive*. Thirty-five of the *Staphylococcus aureus* organisms cultured were resistant to penicillin G. Nineteen of these resistant organisms were successfully controlled. Sixteen were not.

In 19 resolved cases, all had been treated within the first five days after onset of symptoms with a bactericidal drug effective against penicillinase-producing organisms. The 16 cases that progressed to chronic osteomyelitis had been treated with a bacteriostatic antibiotic five days or later after the onset of symptoms. In both groups, the amount, duration, and method of antibiotic administration did not vary. Blood cultures were obtained daily, as long as the child remained febrile or until an organism was identified. If a fluctuant mass became apparent in the involved extremity, needle aspiration of the area was done. The total period of antibiotic treatment in both groups averaged five weeks.

Discussion

Children with acute hematogenous osteomyelitis are not always severely ill.[3,12] They may have a low grade fever, a history of infection of the upper respiratory tract, or a history of trau-

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ma.[2,6] To make an early, proper diagnosis, the musculoskeletal system must be examined carefully. Point bone tenderness is essential in the establishment of an early diagnosis. Delay in diagnosis and treatment of acute osteomyelitis was characteristic of those cases which progressed to the chronic stage. Parents' failure to bring the child's condition to the attention of a physician was one of the reasons for this delay. In addition, confusion on the part of the physician as to what the proper diagnosis was when the child first presented was another source of delay. In otherwise well children presenting with fever and complaining of a tender extremity, acute osteomyelitis must be primarily considered.[4,7]

Diagnosis of acute osteomyelitis must be followed by the immediate institution of parenteral bactericidal antibiotics.[5] Cephalothin or penicillin plus a penicillinase resistant antibiotic such as methicillin, nafcillin, cloxacillin, or oxacillin is indicated. Cephalothin and methicillin require a parenteral route of administration. However, nafcillin, cloxcillin, and oxacillin share the advantage of being able to be given both parenterally and orally.[10]

We suggest the following therapy as a rational approach to the treatment of acute osteomyelitis in children. Daily intravenous doses of penicillin G, 300,000 units per kilogram augmented with methicillin, 200 milligrams per kilogram per day, is given. The administration is divided into six equal doses, each given rapidly over a period of 30 minutes. When the sensitivity reports are received, the appropriate antibiotic is selected. If the child requires a penicillin G resistant antibiotic, methicillin can be continued parenterally until he is afebrile and asymptomatic. At this point, oral oxacillin may be substituted for methicillin. Maintenance of the oral oxacillin should be continued until the sedimentation rate is normal. Six weeks is the average duration of treatment. If a patient has a known allergy to penicillin, cephalothin should be used under close supervision.

The increasing number of penicillin G resistant organisms observed in the 100 cases of acute osteomyelitis studied at The Children's Hospital supports our contention that we cannot blindly rely on penicillin G in the treatment of acute osteomyelitis. Between 1960 and 1965, there was a 78 percent incidence of *Staphylococcus aureus* organisms resistant to penicillin G.

Conclusion

Early recognition of penicillin G resistant *Staphylococcus* is of the utmost importance to the successful resolution of acute osteomyelitis. Treatment should begin with a penicillin G plus a penicillinase-resistant antibiotic such as methicillin. Bactericidal drugs rather than bacteriostatic drugs are strongly recommended. The latter are best reserved for minor infections. If the infection does not respond after five days of the above described treatment, other causative organisms must be considered.

Summary

There were 100 cases of osteomyelitis reviewed at the Children's Hospital between 1955 and 1963. Of the 63 cases in which positive cultures were obtained, 56 were identified as coagulase positive *Staphylococcus aureus*. Between 1960 and 1965, seventy-eight percent of the *Staphylococcus aureus* encountered were resistant to penicillin G.

Two factors appeared to be important in the 19 cases that progressed to chronic osteomyelitis, viz, failure to make early and accurate diagnosis, thus delaying treatment; and failure to initiate treatment with parenteral antibiotics effective against penicillin G-resistant staphylococcus. Treatment should begin with penicillin G plus a penicillinase-resistant antibiotic such as methicillin. Bactericidal drugs rather than bacteriostatic drugs are strongly recommended. The latter are best reserved for minor infections. If the infection does not respond after five days of the treatment described above, other causative organisms must be considered.

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Disk Space Abscess Simulating Disk Herniation

Report of a Case

F. C. Beattie, M.D.

IN THE CASE to be reported, it was most disconcerting to the operating surgeon to incise a bulging annulus and to have yellowish-white pus fill the laminectomy wound. This was surprising in view of the preoperative investigation, which included an apparently normal spine film, a negative chest film, a normal white blood cell count and differential, clear spinal fluid with only an elevated globulin, and a positive myelogram at the lumbosacral level. Only an elevated sedimentation rate of 34 minutes per hour was abnormal. Even the four-day period of observation was misleading in that the temperature curve was perfectly flat for two days prior and for two days after the myelogram (which was performed at the L-4 level). The history and physical findings were not inconsistent with a ruptured disk.

This 35-year-old Negro woman was in good health until her fourth pregnancy, which terminated in a spontaneous abortion in July, 1968. She had some aching in her back at this time with radiation into both legs. The pain persisted until the time of admission on February 2, 1969. At the time of admission, she localized her pain to the low back with radiation out into both hips and into the left leg. The pain was described as continuous and dull, and it was worse when she was on her feet.

She gave a past history of having a benign cyst removed from her breast four years previously. Her father died of leukemia. Her mother is living at 73 and is diabetic and hypertensive.

General physical examination revealed a well-nourished, well-developed Negro woman, who stood with an increased lumbar lordosis. She pointed across the lumbosacral region down the posterior aspect of the right thigh to the outer aspects of the right leg as the areas of complaint. She walked with slow, guarded steps but was able to walk on tiptoes and heels. Straight leg raising was restricted to 45 degrees on the left and 60 degrees on the right. The knee jerks were graded at 1+, and the ankle jerks were 0 to 1+ bilaterally. There was slight questionable hypesthesia over the outer aspect of the left foot. Her admission temperature was normal, blood pressure 110/70 mm. Hg. pulse rate 76 per minute, and respiratory rate 18 per minute. On admission, red blood cell count was 3.68 million per cu. mm., hemoglobin 10.4 gm. per 100 ml., and white blood cell count 4,650 per cu. mm., with differential showing 8 juveniles, 67 segs, 26 lymphs, 5 monos, 4 eosinophils. Urinalysis was reported negative. A routine x-ray examination of the low back revealed the presence of only four lumbar vertebrae, and these were considered normal. (Figs. 1 and 2). A myelogram was performed at the L-4 level on February 3, 1969. This revealed clear spinal fluid with a free flow of the contrast medium but a definite waisting at the level of L-4, S-1. (Fig. 3.) The spinal fluid showed no white blood cells, but 207 red cells. Spinal fluid globulin was reported markedly increased, protein

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69 mg. per 100 ml., and sugar 85 mg. per 100 ml. An x-ray film of the chest was reported normal.

After the initial moment of indecision at surgery, bacteriologic studies of the aspirated pus were ordered immediately. These included Gram and acid fast stains, cultures, and drug sensitivity studies. The next decision was whether to drain and get out or to clean out the disk space. On the first cautious bite of the rongeurs, a large edematous chunk of disk material was removed. Since the remainder of the disk material could extrude and act as a nidus for an epidural abscess, it was decided to remove as much of the disk material as possible. This was done. The next question was how to drain. Should the drain be inserted into the disk space itself, or only down to the laminectomy site? The former was rejected, since it was believed that the pressure of the plastic drainage tube on the nerve root would not only be symptomatic but might cause a pressure erosion of the dural sleeve whose integrity had been carefully preserved. Closed suction drainage was chosen over packing the wound open for fear of introducing a staphylococcus infection down to the exposed dura. After flooding the wound with one million units of aqueous penicillin, the wound was closed in routine fashion.

Postoperatively, an intravenous drip of ten million units of penicillin daily was ordered, while awaiting the result of the culture. The Gram and acid fast stains had been negative and subsequently the cultures were reported negative. Since it was important to determine the infecting organism, special Gram stains were done on the histologic sections of the disk material removed at the time of surgery. Other than revealing a questionable gram-negative rod within one of the polys, no organisms were seen. Acid fast stains of the tissue sections were negative. The pathology report stated that no structures suggesting fungi were identified and that the "Material was consistent with nucleus pulposis showing an active chronic inflammatory process. If antibiotic therapy seems desirable without cultural identification of organisms, the possibility of mixed coccal and bacillary infection should be considered in selecting the agent used."

For ten days postoperatively, the patient spiked a fever of 101 degrees daily, although the presenting symptoms of back and leg pain were relieved. The closed drainage system was productive of 10 to 15 cc. of bloody drainage the first day and nothing thereafter. The drains were removed the fourth day. The wound healed per primum. At no time did she show meningeal symptoms. In the meantime, histoplasmin and febrile agglutination antigen tests were negative.



Fig. 1. Lateral view of lumbosacral spine. Lumbosacral disk space is narrowed. Bone density considered normal.



Fig. 2. Anteroposterior view of lumbosacral spine. Lumbosacral disk space is narrowed. Bone density considered normal.



FIG. 3. Myelogram showing filling defect typical of ruptured disk at lumbosacral level.

Skin test with PPD #1 was negative while PPD #2 was strongly positive. On the tenth day, the antibiotic was changed to Lincocin, 250 mg., four times a day, for two days, thence to Declomycin, 250 mg., four times a day, and methicillin, 250 mg., four times a day, and finally to Combiotic (three hundred thousand units of procaine penicillin, one hundred thousand units of penicillin sodium, and 0.5 gm. streptomycin) without affecting the daily temperature of 101 degrees. Finally, a medical consultant pointed out the obvious fact that we were dealing with a sterile abscess, and all antibiotics were discontinued. The temperature fell to normal over a period of two days. The patient was then allowed up wearing a corset, and after two more days of observation, she was discharged afebrile, and asymptomatic.

She was seen at weekly intervals after discharge and was doing well.

Approximately six weeks after surgery she developed headaches, and a temperature of 100F. She was advised to start taking Prostaphlin, 500 mg., four times a day. Two days later her husband called to say that her temperature had gone up to 102 degrees and that she acted strangely and would not eat. She was seen that day and readmitted to the hospital. At the time of this second admission, she walked with a reeling gait and had difficulty in concentrating. Kernig and Brudzinski signs, straight leg raising tests, reflexes, and sensation of the lower extremities were normal and were confirmed by a neurology consultant. The optic disks were thought to be normal, the lung fields were clear, there were no cardiac murmurs, the sclerae were not icteric, and the liver was not enlarged. The abdomen was diffusely tender. Vaginal examination revealed only diffuse adnexal tenderness. There was full motion in the hip joints, and the Fabre test was negative. Blood cultures were taken. The white blood cell count was 7,150 per cu. mm. with a normal differential, the chest films were again reported normal. Although a spinal tap was obviously indicated, it was deferred in the absence of definite meningeal symptoms for fear of converting a possible epidural abscess into meningitis. During the third hospital day, the patient developed a stiff neck and became progressively more comatose. A spinal tap was then performed. This showed normal pressure with 715 white blood cells per cu. mm., 50 percent lymphocytes, 50 percent polymorphonucleocytes, 450 mg per protein, and 15 mg per 100 cc glucose. Smear and culture were again negative for organisms. She died on the fourth hospital day.

An autopsy was performed and basilar meningitis was found. The lumbar vertebral bodies

were sectioned longitudinally and appeared normal except for some sclerosis of the fifth lumbar and possible erosion of the upper margin of the sacrum. The lumbosacral disk space was obviously infected and contained the watery, yellow pus similar to that encountered at surgery. There was scar tissue in the epidural space at the lumbosacral level surrounding an intact cauda equina. There was a psoas abscess on the right. Cultures taken at autopsy on the unembalmed body have yielded *Mycobacterium tuberculosis.*

The clinical diagnosis was tuberculous abscess of the lumbosacral disk simulating a herniated nucleus pulposis. This was confirmed six weeks after autopsy by a pathologic diagnosis and only after a tuberculous organism had been grown out in culture.

Elevated spinal fluid globulin occurs in ruptured disks when there is a block to the spinal fluid flow.

Comment

Postoperative disk space infections are not unknown. Anyone doing disk surgery can recall one or two cases in his career in which there was a low-grade fever, a sharp increase in the severity of the symptoms, and x-ray evidence of irregularity of the contiguous surfaces of the adjacent vertebrae. As the fever and symptoms subside, the disk space may gradually narrow or the vertebrae may become completely fused. Nor is disk space infection in children a rarity. There is a rudimentary blood supply to the nucleus pulposis,[3] which disappears in adolescence.[6] The infecting organism may be *staphylococcus, streptococcus,* influenza, or typhoid and is usually not tuberculous.[4]

Keon-Cohen reported four cases of lumbar epidural abscess in a series of 700 laminectomies for disk rupture.[5] These were characterized by fever and progression of neurologic symptoms necessitating early surgical intervention. Epstein[2] reported a case of tuberculosis of the spine admitted with a clinical history suggesting a protruded intervertebral disk. Preliminary x-rays of the spine had been considered normal. Myelographic examination showed a filling defect at the interspace between the fourth and fifth lumbar vertebra on the right side, which was considered characteristic of ruptured disk. At operation it was found that the defect had been caused by an indurated pad of fat which on section proved to be tuberculous.

J. Albert Key[6] reviewed the pathology of tuberculosis of the spine in 1940. He pointed out that the infection may originate in the central part of the body, just beneath the anterior cortex of the body, or in the epiphyseal region of the plate. Those originating in the center of the body can spread and cause a collapse of the body. Those under the anterior cortex can erode through the cortex and spread to adjacent vertebrae under the anterior longitudinal ligament. Those in the epiphyseal region can erode into the disk. He further pointed out that the thickness of the cartilaginous plate acts as a barrier to this spread into the disk space of children, but not in adults, since the cartilaginous plate is much thinner.

The radiologic changes incident to tuberculosis of the spine may be very slight in early stages of the disease. Cleveland[2] mentioned that the lesion is rarely diagnosed within six months of the onset of symptoms. As far as myelographic examination of the spine is concerned, Brodin[1] reported on 30 cases of tuberculous spines examined with a water soluble contrast medium. Although the x-ray findings were not specific, he found that characteristic findings were elevated spinal fluid protein and absence of cells. He believed that the elevated protein was a result of compression rather than the presence of tubercle bacilli.

Summary

An abscess of the intervertebral disk was a surprise finding at operation on what was thought to be a ruptured intervertebral disk.

The preoperative investigation gave no hint that infection was present.

The postoperative course and autopsy findings are consistent with a diagnosis of a tuberculous abscess.

Generic and Trade Names of Drugs

Lincomycin hydrochloride monohydrate—Lincocin (Upjohn Company)

Demethylchlortetracycline HCl—Declomycin (Lederle Laboratories)

Sodium oxacillin—Prostaphlin (Bristol Laboratories)

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Wandering Spleen — An Unusual Complication of Infectious Mononucleosis

Report of a Case

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WE HAVE recently observed a spleen, enlarged in association with infectious mononucleosis, that migrated from its usual position in the left upper quadrant to the lower abdomen. At laparotomy, a large hemorrhagic splenic pseudocyst filled the inferior abdomen and pelvis, causing the spleen to migrate from the left upper quadrant to the pelvic area.

Case Report

An 18-year-old white girl was admitted to University Hospitals of Cleveland in March, 1969, for evaluation of an abdominal mass. She had been well until December, 1968, when she developed a syndrome of fever, sore throat, and cervical adenopathy. Improvement followed penicillin therapy, but one week after onset, a sharp nonpleuritic left hypochondrium pain appeared. This was exaggerated by walking and relieved by lying on the left side. It persisted intermittently and was associated with alternating constipation and diarrhea, weight loss, and early satiety with meals. Three months after the onset of symptoms, she was noted to have lymphocytosis, heterophil agglutination of 1:224, and an enlarged spleen in the left upper quadrant documented by abdominal x-ray (Fig. 1). Her symptoms persisted, and soon thereafter, a prominent lower abdominal mass was felt. This prompted her referral to this hospital.

Examination at the time of admission revealed a soft, non-tender, slightly movable lower abdominal and pelvic mass with a prominence in the midline resembling a five-month pregnancy. In the midline, it was possible to delineate the superior aspect, but laterally the margins were difficult to determine. The hematocrit was 39 percent and white blood cell count (WBC) 4700 per cu. mm. with 63 percent segmented neutrophils, 29 percent lymphocytes (few atypical), 6 percent monocytes, 1 percent eosinophils, and 1 percent basophils. The Monospot Test was strongly positive, and heterophil titer after absorption was 1:80. Urinary chorionic gonadotropins and lupus erythematosus preparations were negative; serum glutamic oxalacetic transaminase (SGOT) and urate were normal. X-rays of the abdomen revealed a pelvic mass, and intravenous pyelograms showed slight bilateral hydronephrosis-hydroureter with partial obstruction of the ureters at the pelvic brim. An hepatosplenic scan after the intravenous administration of a Technetium-99m- labeled colloidal sulfur delineated an area of uptake in the left lower quadrant (Fig. 2). Percutaneous femoral aortogram visualized the splenic artery traveling an abnormal course to the lower abdomen where it supplied the spleen making up only the superior portion of the abdominal mass (Fig. 3).

At the time of laparotomy, a slightly enlarged spleen was located in the left lower abdomen and

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arising from its inferior surface was a 10 X 14 X 14 cm. purple cystic mass (Fig. 4). There was no torsion of the pedicle nor adhesions, and splenectomy was performed without rupturing the pseudocyst. The spleen and its cyst weighed 1592 grams. On incision, the cyst was found to contain a large amount of chocolate colored fluid. The pseudocyst wall was 1 mm. thick in some sites and was composed of organizing clotted blood that formed a trabecular pattern with shaggy septa. The parenchymal portion of the spleen itself was histologically normal.

Discussion

The normal spleen is held in place by its ligamentous attachments (phrenicolienal, lienorenal, splenocolic ligaments) and the pressure of the other intra-abdominal organs,[1] the combination of which is said to allow only about 1½ inches of mobility.[2] In certain uncommon situations which

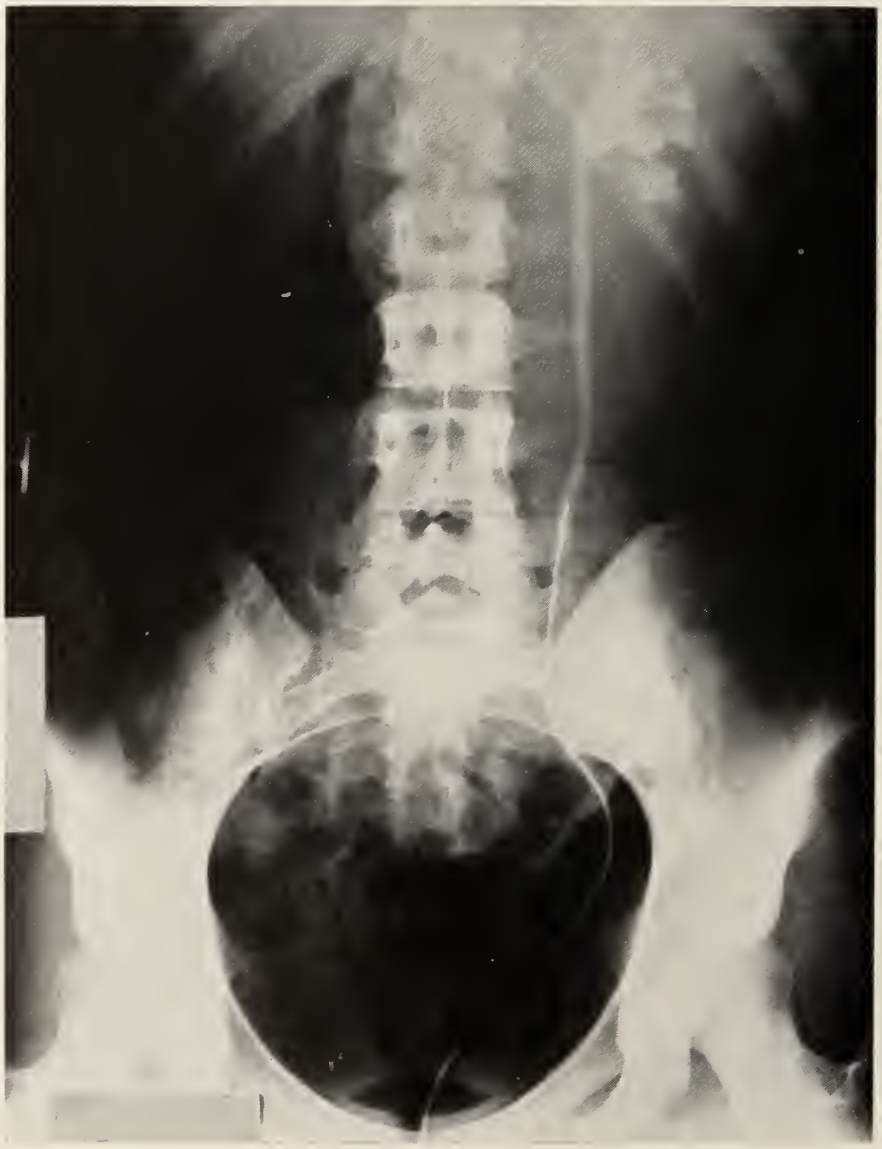


FIG. 1. Abdominal x-ray taken three months after onset of symptoms showing enlarged spleen in left upper quadrant extending across the midline. View shown was taken at time of a left retrograde pyelogram.



FIG. 2. Scintiscan demonstrating normal liver and ectopic position of the migrant spleen.



FIG. 3. Retrograde femoral aortogram demonstrating wandering spleen in left lower quadrant and pelvis as well as the aberrant course of the splenic artery supplying it. Some barium remains from previous barium enema.

predispose to loosening of these supports, it descends to an area other than the left upper quadrant and is then, by definition, a displaced, floating, or more commonly, a wandering spleen. At the time of Bohrer's review in 1940, there were 118 cases of wandering spleen in the medical literature,[3] and we have counted an additional 65 cases since. Of the total number reported, only seven were associated with a hemorrhagic pseudocyst, and none of these was preceded by infectious mononucleosis. Childe in 1905 reported a 54-year-old woman, who, following a febrile illness, developed a tumescence of the lower abdomen which at surgery was found to be a wandering spleen with attached blood-filled cyst.[4] Ferraz in 1952 described an 11-year-old boy with an infra-umbilical abdominal mass which proved to be a 1600 gram wandering spleen and hemic cyst; of interest, is the fact that his postoperative course was complicated by an illness said to be infectious mononucleosis.[5] Four of the spleens in Abell's series of patients with wandering spleens that had undergone torsion on their pedicles contained blood-filled cysts,[6] and one additional case was reported by Dowidar in a woman with splenomegaly secondary to Bilharzial cirrhosis, the correct diagnosis being made preoperatively.

Wandering spleens occur most frequently in the 20 to 40 year old age group, and women outnumber men by greater than 10:1. The most common locations of displacement, in decreasing order of frequency, are the left side of the abdomen, pelvis and abdomen simultaneously, pelvis, right lower quadrant alone, left lower quadrant alone, and rarely, the thorax.[6] They may present clinically as an abdominal mass, either asymptomatic or associated with vague gastrointestinal or menstrual symptoms, but more often are heralded by an acute abdominal catastrophe, the latter due to torsion of the organ on its pedicle and subsequent infarction. As the pedicle twists, it may involve the tail of the pancreas or intestine giving the symptoms referable to infarction or obstruction of these organs. The diagnosis is often made at laparotomy but aortography has been used to diagnose the condition preoperatively.[7]

A few cases may be due to developmental defects as suggested by associated congenital deformities (diaphragmatic hernia of Bochdalek, absence of gastrocolic ligament, long mesentery,[3] pyloric stenosis, anomalous venous drainage[8]) but the majority seems to be acquired. An enlarged spleen has been thought more susceptible to migration because of its weight; eight patients in Abell's series had malarial splenomegaly. But size as a factor in migration is difficult to assess, as a wandering spleen often enlarges due to the congestion caused by torsion of its pedicle and the subsequent obstruction of the splenic vessels. If size is truly an important factor, one wonders why the large spleens of leukemia and myeloid metaplasia don't undergo displacement. The high



Fig. 4. Spleen and its pseudocyst immediately after surgical removal. Scale in centimeters.

incidence of wandering spleen in women of childbearing age suggests that an acquired laxity of abdominal support may also be an important factor.

Rupture of the spleen in infectious mononucleosis is a well documented complication of this usually benign disease and occurs in approximately 0.2 percent of cases.[9] Less commonly, the bleeding is confined beneath an intact capsule, thereby forming a subcapsular hematoma. This complication can be easily explained and even anticipated by the histology of the spleen in acute infectious mononucleosis. Atypical lymphocytes are suffused throughout the pulp and sinuses, and the capsule shows edema and infiltration of atypical lymphocytes occasionally to the extent of near dissolution.[10] These changes bring about generalized weakening of the supporting structures and probably predispose to hemorrhage and rupture.

We are postulating that in this patient the spleen, enlarged due to infectious mononucleosis, was contused by some minor trauma, lacerating the parenchyma, but not disrupting the capsule. A subcapsular hematoma formed, underwent enlargement and liquifaction and thereby became a hemorrhagic pseudocyst. Its bulk caused the symptoms and probably as well was a factor resulting in the migration of the spleen and its pseudocyst into the lower abdomen.

Summary

An 18-year-old girl suffered displacement of her spleen into the lower abdomen in association with infectious mononucleosis. Abdominal symptoms made splenectomy necessary and at surgery a large splenic pseudocyst was found attached to the migrant spleen. This complication of a relatively common disease has not been previously reported.

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EXERCISE AND INFECTIOUS HEPATITIS. — To compare the effect of strenuous exercise on recovery time in 199 American servicemen in Vietnam with infectious hepatitis to that in 199 patients with infectious hepatitis treated in the customary fashion, the exercise group was started on the program of strenuous exercise for approximately three hours daily at the time their symptoms were considered to be slight, irrespective of the degree of liver-function abnormality.

No statistical difference was found between the two groups in the duration of elevation of serum bilirubin or in relapse rate. Exercise did not adversely affect those whose maximum serum bilirubin was greater than 3.0 mg per 100 ml or those over 30 years old. No difference in duration of disease was found in those who were involved in strenuous activity at the time of onset of illness as compared to those involved in light activity.

Strenuous activity does not appear to have any adverse effect on the acute course of infectious hepatitis in previously healthy young men.—Captain Lawrence H. Repsher, MC, AUS, and Major Robert K. Freebern, MC, USA, Washington, D.C.: *The New England Journal of Medicine,* 281:1393-1396, December 18, 1969.

Gangrene of the Bladder

Report of a Case

Hagop A. Dikranian, M.D. and Benjamin Pilloff, M.D.

ALTHOUGH gangrene of the bladder is an interesting but rare clinical entity, the possibility of its occurrence should always be considered as a complication after radical pelvic surgery, radiation therapy for malignant tumor in the pelvis, and severe arteriosclerotic disease of the abdominal aorta and its major terminal branches. This condition was first described by Willis in 1650; however, the largest accumulation of cases was not presented until 1934, when Stirling and Hopkins[1] comprehensively reviewed 207 cases and included reports of two others they had personally encountered. Their review reported a mortality rate of 60 percent.

The purpose of this paper is to describe a case of gangrenous cystitis secondary to severe arteriosclerosis obliterans with thrombosis of the abdominal aorta and common iliac arteries. The etiology, pathology, clinical findings, and treatment of this condition are also briefly discussed.

Case Report

The patient, a 73-year-old white man, was admitted to the Veterans Administration Hospital, Dayton, Ohio, January 30, 1969, because of hematuria associated with acute urinary retention. Three weeks prior to admission, the patient had a right cerebral vascular accident. Twelve days after this accident, he developed acute urinary retention. Catheterization was performed and 1000 cc of clear urine was obtained. A second episode of acute retention ensued nine days later, and on this occasion, 300 cc of bloody urine was obtained. The urethral catheter was left indwelling for continuous drainage, and the patient was admitted to this hospital for urologic evaluation and treatment.

Review of the past history revealed the following pertinent findings: arteriosclerosis obliterans of both lower extremities; hypertensive cardiovascular disease; and mild diabetes mellitus.

On admission, the patient was semicomatose and responded only to painful stimuli. Temperature was 100.8F rectally, pulse rate 120 beats per minute, blood pressure 120/80 mm Hg. He had right-sided facial paralysis, left hemiplegia, and coarse rales over both lung bases. Abdominal examination showed a soft abdominal wall with no tenderness or rigidity. No suprapubic masses were present. No abdominal bruit was heard. On the patient's back was a large sacral decubitus ulcer, 6.5 x 5 cm in diameter, covered with necrotic slough. Pulses could not be palpated in the vessels of the lower extremities. The urethral catheter was draining bloody urine of pungent and foul odor. Urine culture grew *Proteus*. Intravenous pyelogram showed a normal right kidney and a contracted, poorly functioning left kidney. Cystoscopy revealed a gray, loose membrane covering the entire bladder wall. No healthy mucosal membrane could be identified. Microscopic examination of multiple biopsies taken from the lateral walls of the bladder showed gangrenous cystitis.

The patient was treated intensively with indicated antibiotics, intravenous fluids, and Neosporin GU Irrigant through a three-way urethral catheter. Streptokinase-streptodornase, 125,000 units in 30 cc of sterile water, solution was instilled twice a day through the catheter in an effort to dissolve the pseudomembrane.

Surgical treatment was not performed because of the patient's poor general condition. He did not respond to the medical treatment, his course progressively worsened, and he died on February 21, 1969.

The postmortem examination revealed extensive necrosis of the bladder mucosa with bilateral chronic pyelonephritis. The distal one third of the abdominal aorta, its bifurcation, and the common iliac arteries were thrombotic and completely obliterated. This was considered as the etiologic cause for the bladder necrosis.

Discussion

The etiology of gangrene of the bladder, as discussed by Cristol and Greene[2] can be divided into two categories, direct causes and indirect

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Reprint requests to Dr. Dikranian, Veterans Administration Hospital, 4100 West Third St., Dayton, Ohio 45428.

Submitted December 2, 1969.

causes. The direct causes are those which produce cellular death of the vesical mucosa. These occur after x-ray and radium irradiation, the introduction of caustic and acidic solutions in high concentrations for the treatment of cystitis, and during protracted chronic cystitis associated with general systemic infections, e.g. typhoid and dysentery. Indirect causes are those disorders which interfere with the blood supply and nutrition of the bladder, such as chronic urinary retention with overdistention of the bladder, extravesical pressure by a gravid-impacted uterus or incarcerated uterine myoma associated with vesical overdistention, thrombosis and occlusion of the abdominal aorta and its terminal branches (as in our case), transuretheral resection of the prostate and bladder neck injuring the blood vessels, and neurogenic bladders associated with overdistention.

Years ago, the most important causes of gangrene were prolonged labor and overdistention of the bladder. Nowadays the wide use of x-ray or radium for the treatment of malignant diseases of the pelvis and peripheral arterial occlusion, caused by arteriosclerosis (Fig. 1), are considered primary etiologic factors.

The clinical picture is that of a severe cystitis with foul-smelling urine. Frequently, acute urinary retention occurs because of plugging of the internal urethral meatus by the sloughing necrotic membranes. Hematuria is caused by separation of the slough.

If the infection extends to the peritoneum, generalized or localized peritonitis will occur. Extension to the kidneys is very common, leading to bilateral pyelonephritis and marked constitutional symptoms.

Cystoscopy reveals the grayish-white necrotic membrane covering the mucosal surfaces. In the intact areas, severe congestion and redness of the mucosa can be found. The bladder becomes markedly contracted with a reduced capacity for retaining urine if regeneration takes place. Healing of the bladder neck gives rise to constriction, and possibly urinary incontinence, because of the damage to the sphincters.

Pathologic findings (Figs. 2 and 3) correlate the cystoscopic picture. The vesical mucosa may exfoliate en masse or cast off into small particles, hence the former name of diphtheritic cystitis. The mucosa is covered by fibrin containing microorganisms, pus, and debris (Fig. 4). The bacteria commonly involved are *Staphylococcus, Streptococcus, Escherichia Coli,* and *Proteus.*

Treatment consists of general supportive measures with hydration and broad spectrum antibiotics to combat infection and possible renal sepsis. The bladder must be drained to permit an



Fig. 1. Gross pathological specimen of the abdominal aorta and the common iliac artery, showing complete occlusion of the lumen by thrombosis caused by arteriosclerosis.





FIGS. 2 and 3. Mucosal surface of the bladder which is completely destroyed and covered by a gangrenous pseudomembrane.

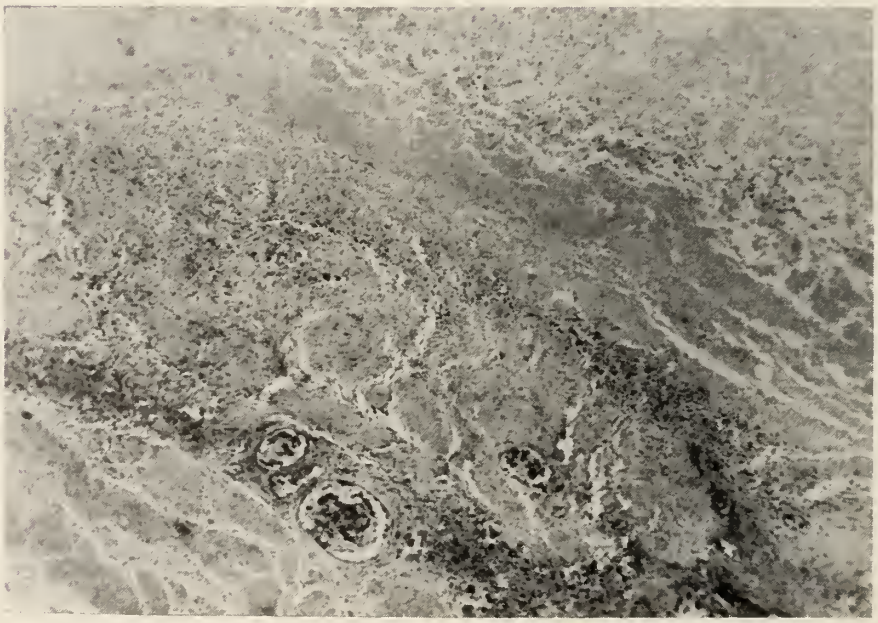


FIG. 4. Microscopic section, H & E stain (x 40), complete destruction of the vesical mucosa with heavy inflammatory cell infiltration of the muscular and submucosal layers.

exit of the pseudomembrane and the toxins. This is best accomplished by suprapublic cystostomy with removal of the membrane or, if the patient is seriously ill, through a wide bore urethral catheter. This treatment is particularly important in the male because of the narrow urethral diameter. There is less chance of urinary retention occurring in the female because of the wide urethra.

Summary

Gangrenous cystitis may result as a complication of extensive arteriosclerosis of the abdominal aorta and its bifurcation. The symptoms and findings are primarily confined to the urinary tract with associated sepsis and toxemia.

The treatment has been directed to insure adequate drainage of the necrotic membrane and toxins and to treat the urinary tract infection.

Since this disease occurs in debilitated, aged patients confined to bed or to wheelchair, the causative factor; namely, arteriosclerotic obstruction of the aorta, might be missed due to lack of symptoms and the more predominant urinary findings.

If the patient survives the disease, the final outcome is a small contracted bladder.

Generic and Trade Name of Drug

Neomycin sulfate-polymyxin B sulfate — Neosporin G.U. Irrigant (Buroughs Wellcome & Co.)

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Self-Evaluation Quiz

1. You are caring for a 22-year-old man who broke his neck in a diving accident 4 weeks ago, and he is now quadriplegic. On rounds, he tells you he has severe throbbing headaches and sweats profusely soon after his catheter (urethral) is irrigated. His temperature is 99.8F orally; pulse rate 52 beats per minute; respiratory rate 16 per minute. What is the next step in making the diagnosis?

   (A) Take a blood culture
   (B) Take a urine culture
   (C) Listen to his chest
   (D) Take his blood pressure
   (E) None of the above

[*From the Department of Physical Medicine, The Ohio State University College of Medicine. The answer is given on p. 401 of this issue.—Ed.*]

2. A 25-year-old man is admitted to the hospital following an automobile accident. Abnormal findings include a contusion and tenderness of the epigastrium. Forty-eight hours later, the patient complains of persistent epigastric tenderness and nausea and a mass palpable in the left upper quadrant of the abdomen. Roentgenograms after a meal of barium sulfate show anterior displacement of the stomach by the mass. The most likely diagnosis is:

   (A) Subcapsular hematoma of the spleen
   (B) Dissecting hematoma of the abdominal wall
   (C) Pancreatic pseudocyst resulting from trauma to the pancreas
   (D) Abscess of the lesser omental bursa

[*From the Department of Surgery, The Ohio State University College of Medicine. The answer and references are given on p. 401 of this issue.—Ed.*]



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during December. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

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C. Lawton Gerlinger, Jr., Dayton
Dan R. McFarland Dayton
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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during January. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

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Marvin Z. Slesh Mentor

MAHONING
George R. Barton Girard
William Katz Youngstown
Lawrence M. Pass Youngstown

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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during February. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

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CLARK
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Babulal K. Shah, Williamsburg

COLUMBIANA
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Murray S. Renfrew, Archbold

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Hope H. Snider, Oberlin

MARION
Robert S. Jessup, Marion

MUSKINGUM
L. Joe Porter, Zanesville

PIKE
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Richard C. Barr, Massillon
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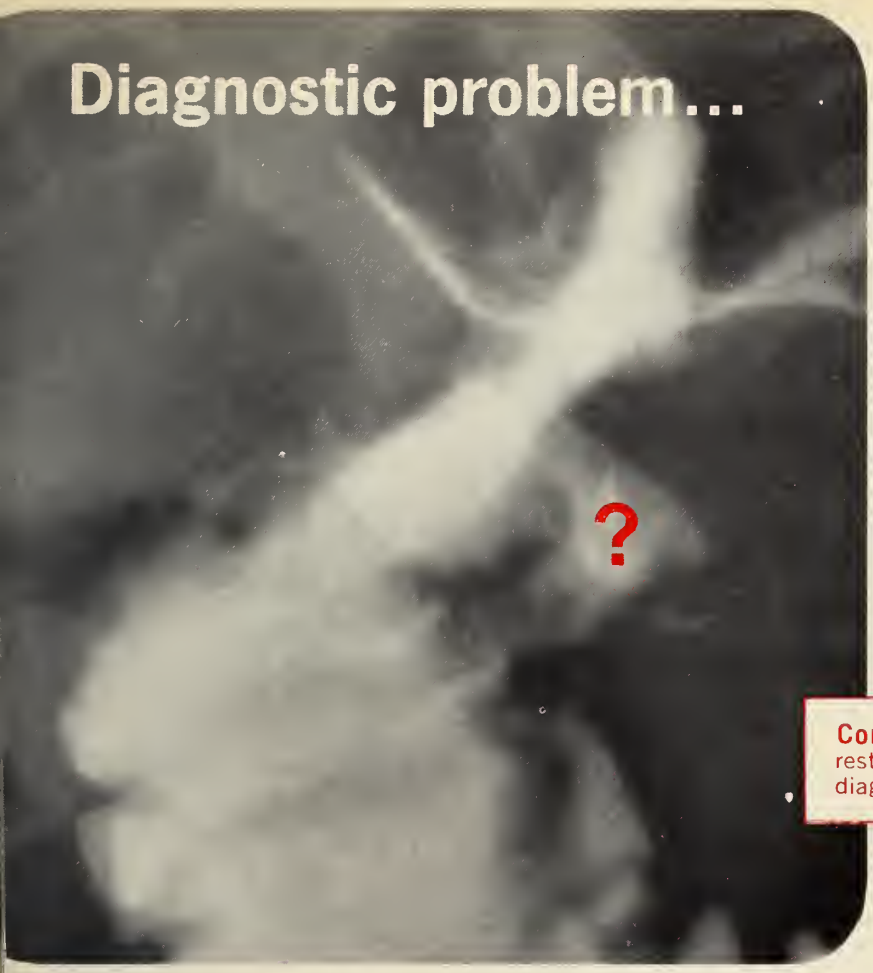
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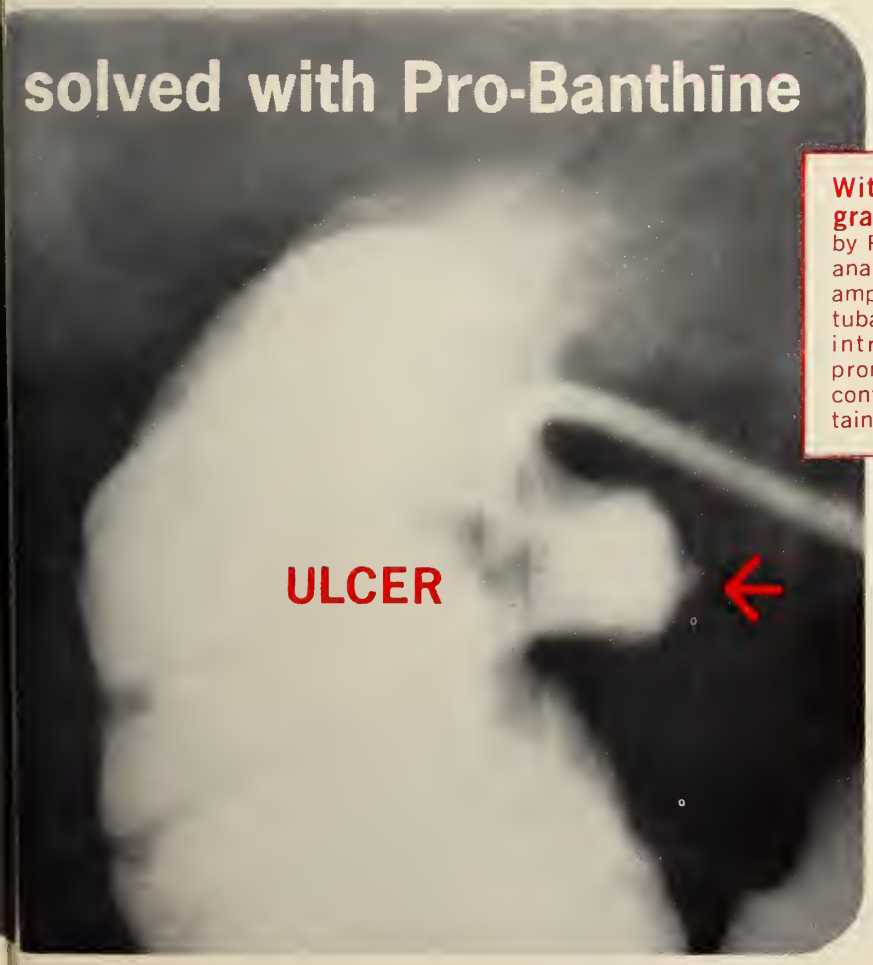
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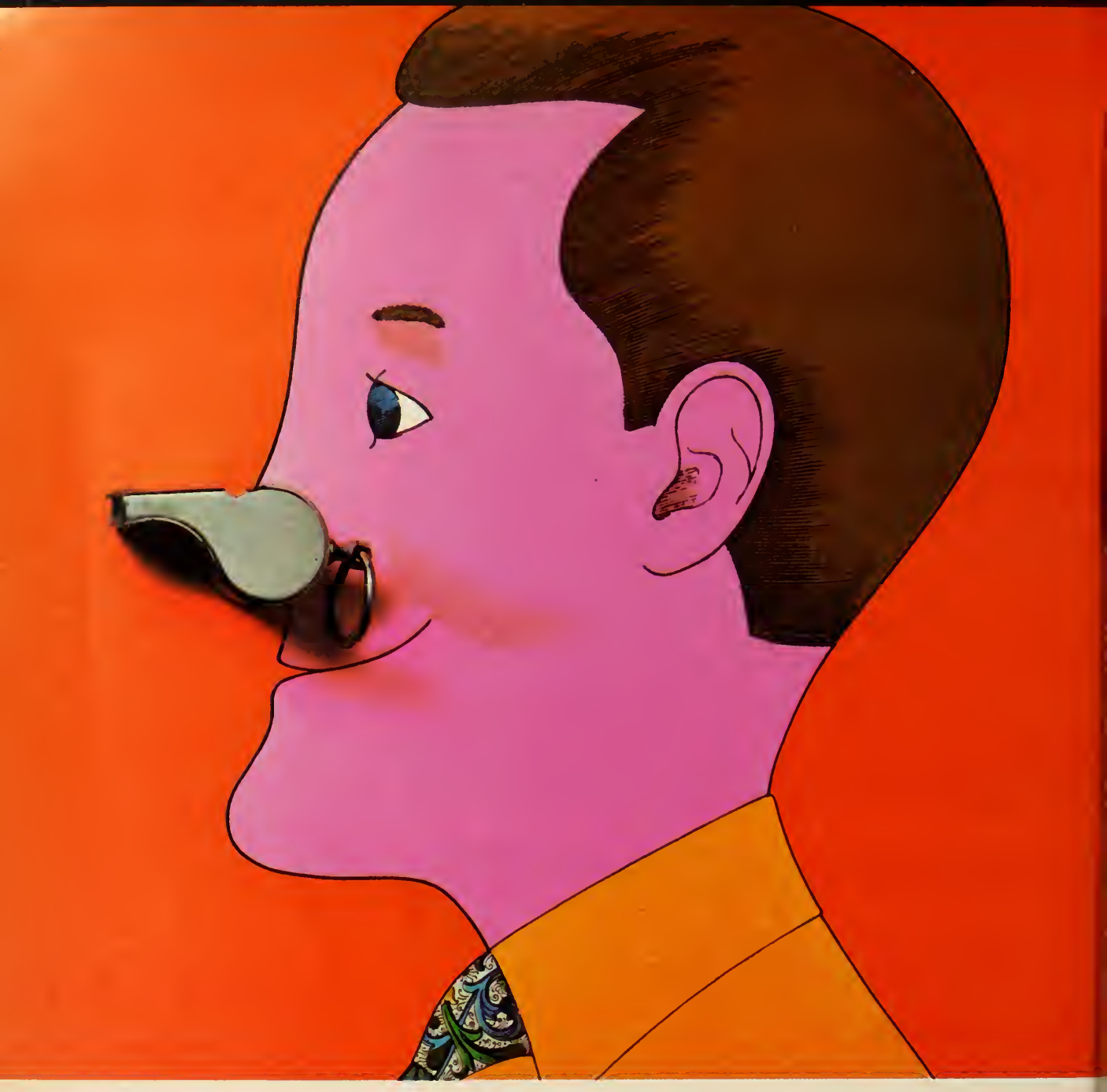


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Tumor Conference — Youngstown Hospital Association; two hours a day, once a week, through June, 1970; for specialists and nonspecialists.

Electrocardiography Review — Youngstown Hospital Association; 1½ hours a day, two days a month; through June, 1970; for specialists.

Psychiatric Treatment Methods — Veterans Administration Hospital, Brecksville; three hours a day, one day a month, October 8 through May 13, 1970; for specialists and nonspecialists.

April

One Week Physician Course—Nuclear Medicine — April 13-18; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

Athletic Injuries—Marvin McClellan, M.D., Cincinnati; Fort Steuben Academy of Medicine, Fort Steuben Hotel, Steubenville, April 14, 8:15 p.m.

22nd Annual Freedman Lectures in Diagnostic Radiology — University of Cincinnati College of Medicine, April 18-19; Lectures by Dr. Jerome Shapiro, director, Department of Radiology, Boston City Hospital, and professor and chairman of radiology at Boston University Medical School; contact Dr. Benjamin Felson, Department of Radiology, Cincinnati General Hospital, 234 Goodman St., Cincinnati 45229.

Investigation of Thyroid Disease—Trumbull Memorial Hospital, Warren, April 22.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Postgraduate Course in Pathology—Cleveland Clinic Educational Foundation, 2020 E. 93rd Street, April 22-23; for specialists and nonspecialists.

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown — **Chronic Pancreatitis,** Bertram Fleshler, M.D., Case Western Reserve University, April 23.

Visiting Professor of Surgery Series: St. Elizabeth Hospital, Youngstown — **Changing Trends in the Treatment of Breast Cancer; Surgical Management of Acute and Chronic Pancreatitis,** Robert E. Hermann, M.D., Cleveland Clinic Foundation, April 23.

Annual Laboratory Animal Medicine Conference—University of Cincinnati College of Medicine, April 25 at Christ Hospital, Cincinnati.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; April 13 — "Mechanisms of Action of Antibiotics," Drs. G. Butcher and N. Pappas; April 27 — "Bronchiectasis — A Review," Drs. H. Bennett and D. Roble.

May

Fifth Annual Conference on the Newborn — Ohio State University College of Medicine, 410 West 10th Avenue, Columbus 43210; May 6; for physicians and nurses.

Progress in Cardiovascular Diseases — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; for specialists and nonspecialists; May 6-7.

Radiology — Youngstown Hospital Association, South Unit, Thursday, May 7, 8:00 a.m.; Guest Professor for the John Heberding Lecture, Milton Elkins, M.D., professor and chairman of radiology at Albert Einstein College of Medicine, New York.

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown —**Tall Girl Syndrome,** T. S. Danowski, M.D., University of Pittsburgh, May 7; **Glomerulonephritis,** Alvin Shapiro, M.D., University of Pittsburgh, May 21; **Infectious Hepatitis,** Edward Rotheram, M.D., University of Pittsburgh, May 28.

Second Annual Seminar — Trauma of the Head and Neck — University of Cincinnati College of Medicine, CONMED, Eden and Bethesda Avenues, Cincinnati 54219; May 7-9; specialists and nonspecialists.

One Week Physician Course—Nuclear Medicine — May 11-16; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

1970 Annual Meeting, Ohio State Medical Association, Columbus, May 11-15; hours of postgraduate short courses; general session, specialty section and specialty society programs.

Prevention of Cancer—St. Elizabeth Hospital, Youngstown, May 14, Emmanuel Farber, M.D., Ph.D., chairman, Department of Pathology, University of Pittsburgh.

Radiology—Annual Meeting of the Ohio State Radiological Society, May 15-17 at the Cleveland-Sheraton Hotel, Cleveland; convention chairman, Theodore J. Castele, M.D., Lutheran Hospital, 2609 Franklin Blvd., Cleveland 44113.

Kidney Disease Symposium — University of Cincinnati Medical Center, May 20.

Advances in Dermatology — Cleveland Clinic Educational Foundation, May 21-22; for specialists and nonspecialists.

Tuberculosis and Respiratory Diseases — Cleveland-Sheraton Hotel, Cleveland, May 24-27; sponsored by the American Thoracic Society and National Tuberculosis and Respiratory Disease Association, 1740 Broadway, New York 10019.

Refresher Course in Diagnostic Radiology — University of Cincinnati Medical Center, May 24-29.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; May 11 — "Virilism," Drs. C. McGowen and N. Suanprasert; May 25 — "Hypertension in Pri-

mary Renal Disease," Drs. R. Bacani and S. Young.

June

Children's Hospital, Akron, Resident-Alumni Days, June 2-3.

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown —**Pericarditis,** James Leonard, M.D., University of Pittsburgh, June 4; **GI Bleeding, Etiology Undetermined; Malabsorption,** George Gabuzda, M.D., Case Western Reserve University, June 18.

Otologic Surgery, Using Live Color Television — University of Cincinnati Medical Center, June 5-9.

One Week Physician Course—Nuclear Medicine — June 8-13; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; June 8 — "Fungal Infections of the Skin," Drs. K. Lloyd and B. Thimmappa; June 22 — "Diabetic Neuropathy," Drs. L. Green and W. Tsang.

Second Annual Urologic Outing on Controversies in Urology — Sponsored by The Ohio State University Division of Urology at Burr Oak State Park, Ohio, on June 29, 30, and July 1. Modern, air-conditioned facilities. Please contact Program Director Chester C. Winter, M.D., Division of Urology, Ohio State University Medical Center, 410 W. 10th Avenue, Columbus 43210.

Answers to Self-Evaluation Quiz

Page 393 Question 1. (D) In spinal cord injuries which are above the level of T5 or T6 there is a substantial portion of the sympathetic trunk which is isolated from control of higher centers. Therefore, any noxious stimulus such as changing catheter, rectal stimulation, dilatation of the bladder can provoke a massive sympathetic activation which would raise the pressure, in many cases, to above 300 mm of mecury systolic. So the diagnosis would be made very easily by taking his blood pressure.

Page 393 Question 2. (C)

References: Werschky, L. R., and Jordan, G. L.: Surgical Management of Traumatic Injuries to the Pancreas. *Amer. J. Surg.,* **116**:768-776, 1968.

Thomford, N. R., and Jesseph, J. E.: Pseudocyst of the Pancreas: A Review of Fifty Cases. *Amer. J. Surg.,* **118**:86-94, 1969.



OSMA GENERAL SESSION SPECIAL

WEDNESDAY, MAY 13, 1970
2:00 P.M.

Main Auditorium, Veterans Memorial Building

ROGER O. EGEBERG, M.D.

ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS
Department of Health, Education, and Welfare
Washington, D.C.

We are fortunate to have a former Ohioan take time from his busy schedule to speak to Ohio physicians. We invite YOU to be present from 2:00 p.m. - 3:00 p.m. and hear what Dr. Egeberg has to share with us. Many of you will remember that Dr. Egeberg was in private practice in Cleveland, Ohio for a number of years.



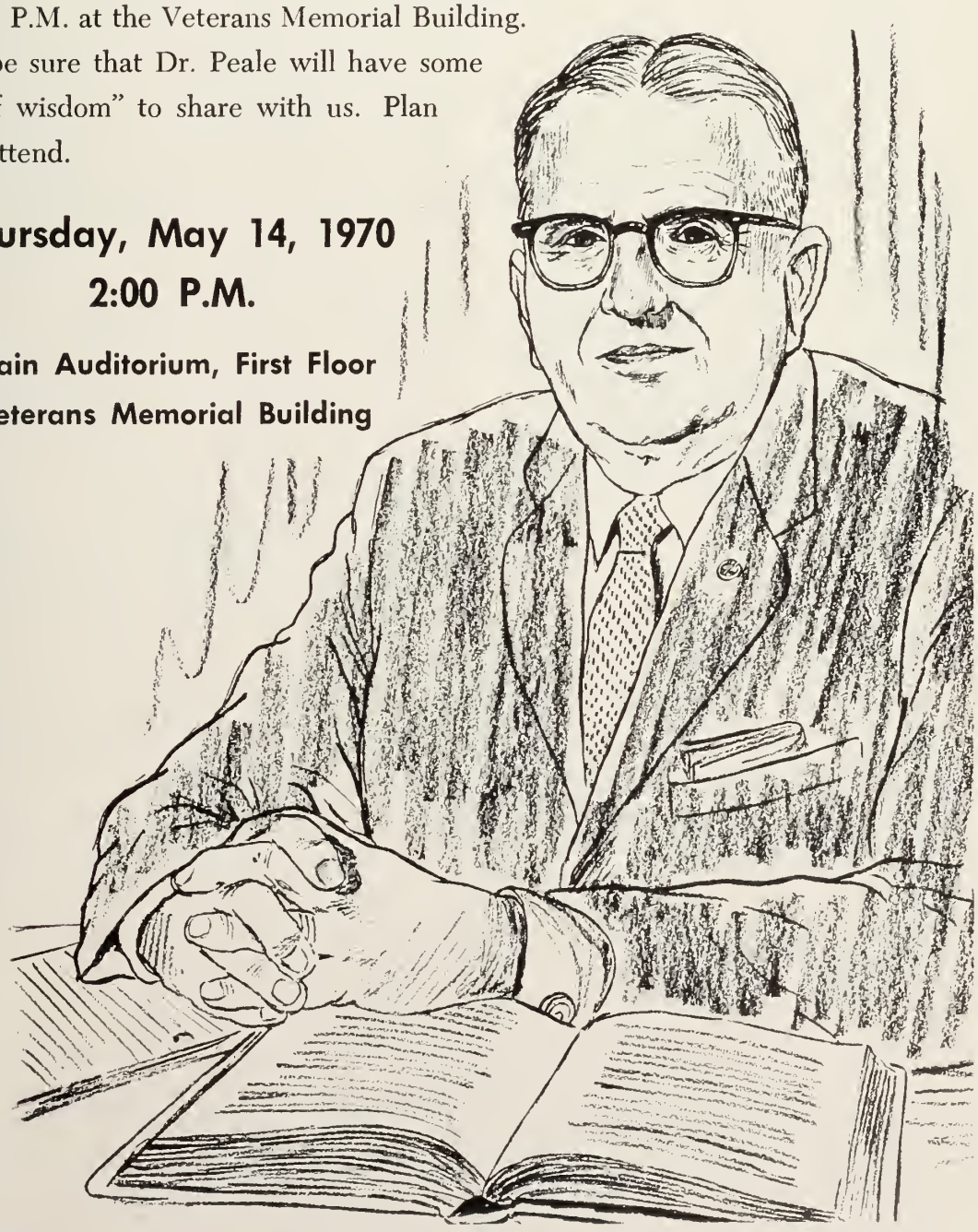
"THE POWER OF POSITIVE THINKING"... has become

almost synonymous with the name DR. NORMAN VINCENT PEALE. Probably no other minister of our time has a more far-flung pulpit than Dr. Peale. Through his books, radio and television programs, speeches and published sermons he has reached and is reaching millions of people throughout the world.

We are privileged to have this former Ohioan as our OSMA General Session speaker on Thursday, May 14 at 2:00 P.M. at the Veterans Memorial Building. We can be sure that Dr. Peale will have some "words of wisdom" to share with us. Plan now to attend.

Thursday, May 14, 1970
2:00 P.M.

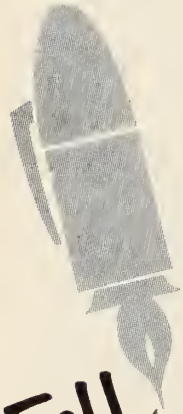
Main Auditorium, First Floor
Veterans Memorial Building



Remember: REGISTER NOW... AVOID LONG LINES SAVE TIME...



Remember the convenience of pre-registration last year? No long lines, no fumbling for your credentials, everything for the meeting in one envelope. It did save time, didn't it? It was so successful that we will be offering this service again this year. In case you have forgotten the proeedure, HERE IS HOW IT WORKS – after OSMA receives your PRE-REGISTRATION FORM we will check membership and fill out your registration card. We will then make a badge for you and your wife if you have indicated that she will be attending, place your badge, program and requested social function tickets and luncheon tickets in an envelope in your name. Then all you need to do is come to the PRE-REGISTRATION DESK and ask for your envelope in your name and you are ready to visit the exhibits and attend the meetings of your choice. Make ONE STOP do it, you will be glad you did!!!



Fill It Out

PRE-REGISTRATION FORM

1970 Annual Meeting
Columbus, Ohio

Ohio State Medical Association
May 11 - 15, 1970

Name _____
(Please Print)

Address _____
(Number and Street) (City) (State)

I am:

- ☐ OSMA Member
- ☐ Official OSMA Delegate
- ☐ Official OSMA Alternate
- ☐ Non-member Physician
- ☐ Guest
- ☐ Medical Student
- ☐ Scientific Exhibitor
- ☐ Executive Secretary
- ☐ News Media

Please prepare guest badge for my spouse.

_____
(Please Print Name)

– SOCIAL FUNCTION TICKETS – RESERVATIONS

Note: (No tickets reserved without money)

Make checks payable to:
Ohio State Medical Association

Mail this form to:
Ohio State Medical Association
17 South High Street, Suite 500
Columbus, Ohio 43215

Wednesday, May 13, 1970 – 11:30 A.M.
"OMPAC Luncheon" Number
Sheraton-Columbus Hotel
$5.00 per person .....

Wednesday, May 13, 1970 – 7:00 P.M.
"For East Fling"
Sheraton-Columbus Hotel
$12.00 per person .....

Thursday, May 14, 1970 – 12:00 Noon
"Exhibitors Luncheon"
Veterans Memorial Building
$4.00 per person .....
(Complimentary to Exhibitors)

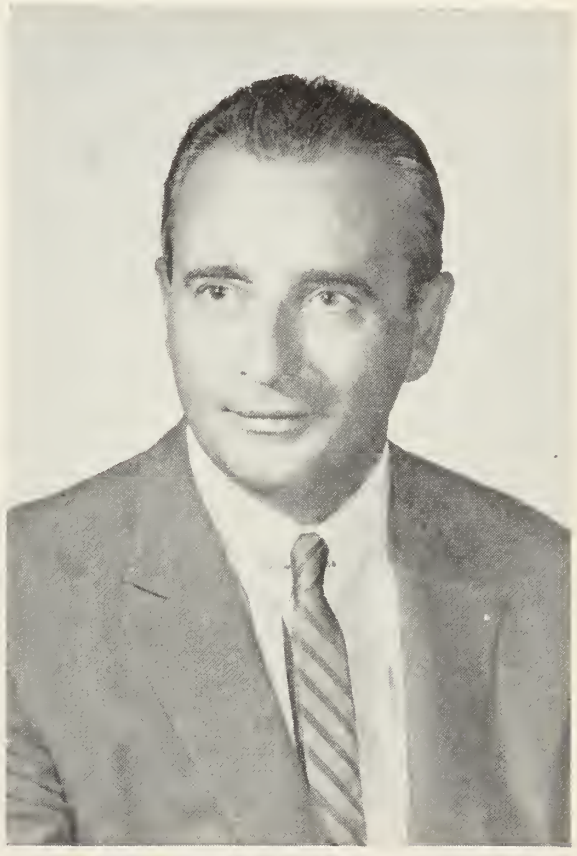
MAIL IT TODAY



DID YOU KNOW??

On May 10, 1970, Rex Morgan, M.D., will have been in practice 22 years.





NICHOLAS P. DALLIS, M.D.

His practice, of course, has been limited to the comic pages of some 400 newspapers in the U.S. and Canada, and in 35 Foreign countries.

The author, NICHOLAS P. DALLIS, M.D., former Toledo physician turned full time author of three comic strips, i.e., Rex Morgan, M.D., Judge Parker and Apt. 3-G will share "what his non-fictional patients think about the Medical Profession."

Many Toledo, Ohio people will remember Dr. Dallis as a practicing psychiatrist in the Toledo area for 15 years. Make it a must to attend this GENERAL SESSION on TUESDAY, MAY 12 at 1:30 P.M., VETERANS MEMORIAL BUILDING.

The Title of Dr. Dallis' presentation will be...

"A Fictional Doctor Reveals What his Non-Fictional Patients Think About the Medical Profession"

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Columbus May 11 - 15

Leading Downtown Columbus Hotels at Prevailing Rates

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Doubles	$20.00 - $25.00
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Neil House Motor Hotel
41 South High Street

Singles	$11.00 - $19.00
Doubles	$14.00 - $18.00
Twins	$15.00 - $23.00

Southern Hotel
South High and Eost Moin Streets

Singles	$10.00 - $15.00
Doubles	$13.50 - $15.00
Twins	$14.00 - $17.00

Holiday Inn-Downtown
175 Eost Town Street

Singles	$13.50
Doubles	$18.50
Twins	$18.50

Christopher Inn
300 East Broad St.
(Woman's Auxiliory Headquarters)

Singles	$13.50 - $15
Doubles	$18
Twins	$20

Pick-Fort Hayes Hotel
31 West Spring Street

Singles	$12.00 - $17.
Doubles	$16.00 - $20.
Twins	$16.00 - $20.

All rates subject to change.

If you plan to share a room, please indicate name of roommat

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(Mail to Hotel of Choice)

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_____Columbus, Ohi
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Associatio Annual Meeting, May 11 - 15 (or for period indicated).

_____Single Room _____Twin Room

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Price Range_____

Arrival: May_____at _____ A.M. _____ P.M

Departure: May_____at _____ A.M. _____ P.M

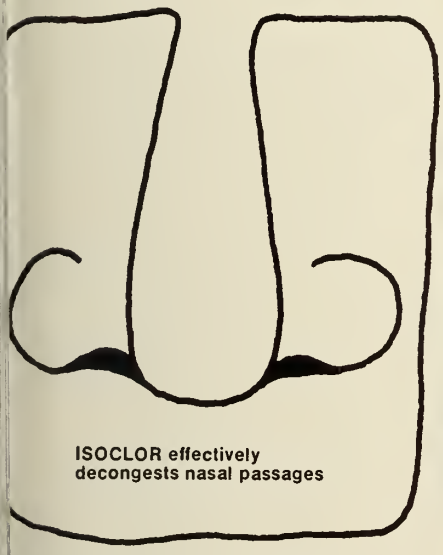
PLEASE VERIFY MY RESERVATION

Name_____

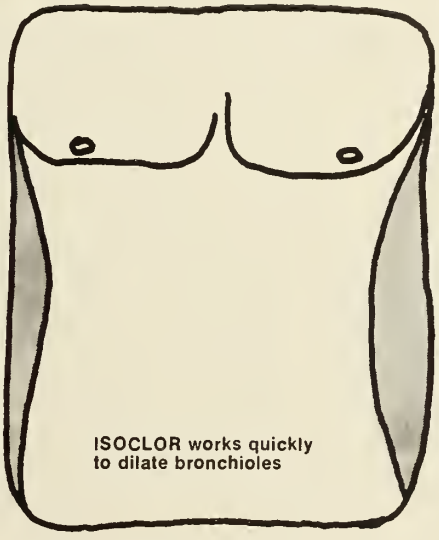
Address_____

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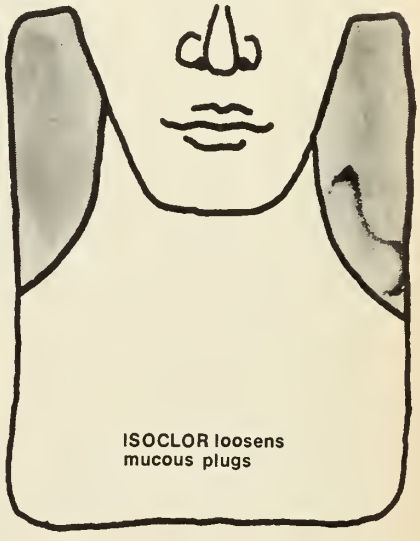
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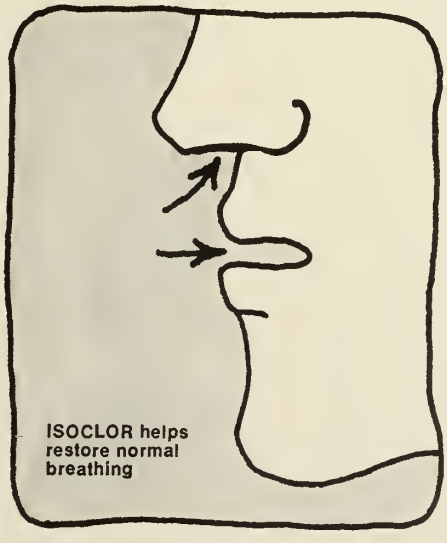
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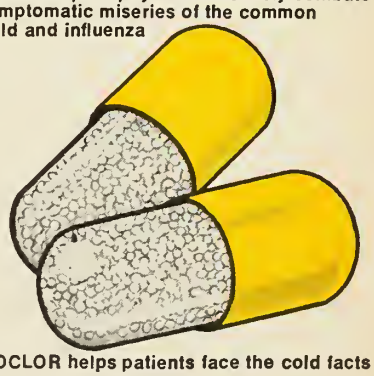


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CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

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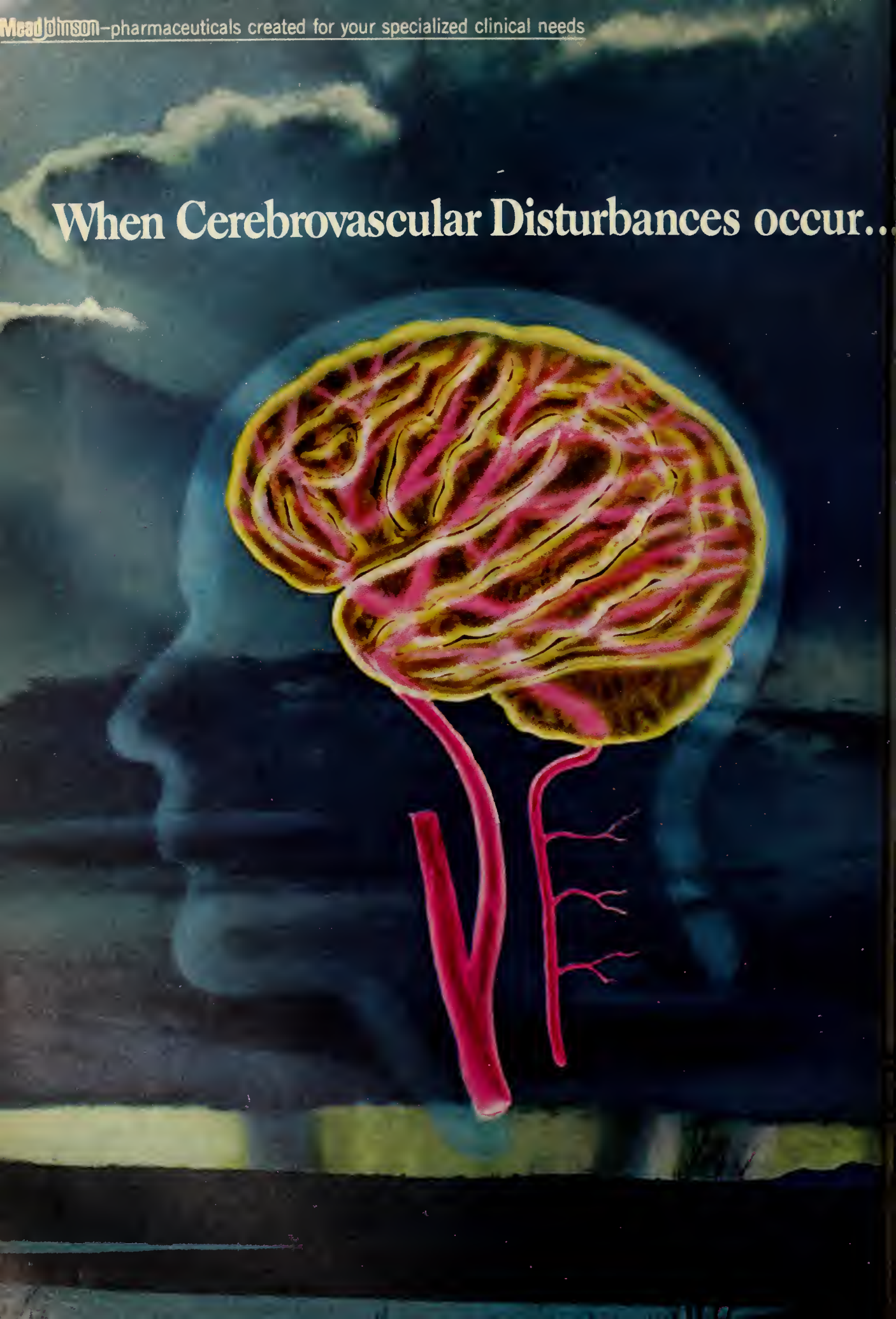
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30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
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New 20 mg. strength now available: Vasodilan 20 mg. tablets for greater dosage simplicity and convenience. Recommended *initial* dose: one 20 mg. tablet q.i.d.

...gh not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of ...prine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] and observation of clinical improvement.[2-4]

...dications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), ...ud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **...position:** VASODILAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications ...autions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial ...ng. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 ... more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not ...mended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas, ...lman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, ...and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 ... 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology ...37 (Feb.) 1964.

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S A M A SPEAKS OU

At the invitation of the Ohio State Medical Association, SAMA Chapters from the four medical schools of Ohio will have a program sponsored by the Chapters. In line with our 1970 OSMA Annual Meeting Theme, "TOGETHER WE CARE," we are certain that the medical students will have some thought provoking views from the standpoint of Today's Medical Students, for the already established practicing physician. Let us support this program by our attendance . . . hear what the future physicians of tomorrow have to say.



A View Of The Medical Profession By Today's Medical Students

Thursday, May 14, 1970 11 a.m.

Assembly Hall, Veterans Memorial

11 a.m. "Why We Think The Way We Do"
Mr. Dennis B. Dove, 3rd year student
University of Cincinnati College of Medicine
SAMA Chapter President

11:20 "A Disillusioned Student Views The Profession"
Mr. George R. Schuerger, 2nd year student
Ohio State University College of Medicine

11:30 "Return To Private Practice Apprenticeships"
Mr. Richard W. Pine, 1st year student
Case Western Reserve University College of Medicine

11:40 "The New Physician – Patient Care and Community Involvement"
Mr. Joseph C. Ward, 2nd year student
Ohio State University College of Medic

11:50 Audience reaction via question and answer period
Mr. Robert Gagel, 3rd year student
Ohio State University College of Medic
SAMA Chapter President, Moderator

This program, in conjunction with the 1970 Annu Meeting of the Ohio State Medical Association, is sponsored by the Student American Medical Assoc ation Chapters at:

Ohio State University
University of Cincinnati
Case Western Reserve University
Medical College of Ohio at Toledo

Candidate for Office of President-Elect

IN ACCORDANCE WITH Section 1 (a) of Chapter 5 of the OSMA Bylaws, the following nomination of a candidate for the office of President-Elect of the Ohio State Medical Association has been filed with the Executive Secretary 60 days prior to the meeting of the House of Delegates at which the election is to take place:



P. JOHN ROBECHEK, M.D.
CLEVELAND, OHIO

Academy of Medicine of Cleveland

February 27, 1970

Mr. Hart F. Page
Executive Secretary
Ohio State Medical Association
17 South High Street
Columbus, Ohio 43215

Dear Mr. Page:

By constitutional privilege, we are pleased to nominate P. John Robechek, M.D., Fifth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association. The Board of Directors of the Academy of Medicine of Cleveland voted unanimously to support Dr. Robechek's nomination.

Dr. P. John Robechek is qualified by membership in good standing in the Academy of Medicine of Cleveland, the Ohio State Medical Association and the American Medical Association.

Respectfully submitted,

Leo Walzer, M.D.
President

Curriculum Vitae

Education:
- Cleveland Public Schools
- A.B., Adelbert College, Case Western Reserve University, 1937
- M.D., School of Medicine, Case Western Reserve University, 1940
- Licensed in Ohio, 1940

Medical Organizations:
- Academy of Medicine of Cleveland
- Ohio State Medical Association
- American Medical Association
- American College of Surgeons

Specialty: Surgery
- Certified, American Board of Surgery, 1947
- Fellow, American College of Surgeons, 1948
- Founding Member, Cleveland Surgical Society
- Associate Surgeon, St. Luke's Hospital, Cleveland
- Head, Department of Surgery, Marymount Hospital, 1964-68.

Military Service: U.S.N.R.—Active duty, 1944-46

Activities in Medical Organizations:
- President, Academy of Medicine of Cleveland, 1960-61
- President, Medical Staff of St. Luke's Hospital, Cleveland, 1957
- Member, Ohio Cancer Coordinating Committee, Inc.
- Liaison Fellow, Cancer Commission of America —College of Surgeons, for Fifth District
- Councilor, Fifth District, OSMA, 1964 to present
- Treasurer, Ohio Chapter, American College of Surgeons, Inc., 1970-
- Chairman, Auditing and Appropriations Committee, Ohio State Medical Association, 1969-
- Chairman, Multidiscipline Committee of Ohio State Medical Association that drafted nationally recognized "Essentials for a Comprehensive Home Care Program"

(Continued on Next Page)

(Candidate—Continued)

Alternate Delegate to AMA House of Delegates, 1961-1969

Delegate to AMA House of Delegates, 1970-

Other Organizations:

Trustee, Blue Cross of Northeast Ohio, 1961-

Member, Medical Advisory Committee on Blue Cross of Northeast Ohio

Member, Committee on Planning and Development, Academy of Medicine of Cleveland

Member, Cancer Committee, Northeastern Ohio Regional Medical Planning Committee

Member, Cleveland Skating Club

Member, Medical Arts Club

Member, Aesculapian Society

Born: Cleveland, Ohio, February 23, 1914

Religious Affiliation:
Fairmount Presbyterian Church

Married to Ruth Driggs, three children: Mary Dow Ross, M.A. from Northwestern University; Madison, Wisconsin; Sara K. Robechek, Secretary to Staff Consulting Department, Ernst and Ernst; John D. Robechek, Senior at Cornell University College of Engineering

GI Symposium Scheduled in Lexington

Ohio physicians have a special invitation to attend programs scheduled at the University of Kentucky, at one of which a prominent Ohio surgeon will speak. The program has been announced as follows:

1. A symposium on gastrointestinal disease entitled "Bring Your Own Lesion." May 8 and 9, 1970. Guest lecturers: Dr. Robert Zollinger, professor and chairman, Department of Surgery, Ohio State University, and Dr. Stephen L. Wangensteen, associate professor, Department of Surgery, University of Virginia. Fee: $40.

2. "Ill Winds," A course on Current Progress in Respiratory Therapy. April 17 and 18, 1970. Fee: $25.

Both of these courses will be held at the Albert B. Chandler Medical Center, Lexington. For further information contact Frank R. Lemon, M.D., Associate Dean, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Regional Medical Program Coordinator Named

William G. Pace, III, M.D., assistant dean of the Ohio State University College of Medicine, has been appointed program coordinator of the Ohio State Regional Medical Program. He also has been named director of the Computer-Assisted Instruction Study, a project funded by the program.

The appointments, which became effective on February 1, were announced by the chairman of the OS-RMP Regional Advisory Committee, Richard L. Meiling, M.D., dean of the OSU College of Medicine.

Dr. Pace will supervise all activities of the Ohio State RMP which promotes and sponsors community medical projects dealing with heart disease, cancer, stroke and related diseases. One of 55 such programs in the nation created by Congress in 1965, it serves a 61-county area of the state and is affiliated with the OSU College of Medicine.

Dr. Pace replaces Neil C. Andrews, M.D., former assistant dean of the OSU College of Medicine, who left his post in late January to become Program Coordinator of Area II of the California Regional Medical Program at Davis, California.

Dr. Pace, who has been with the OSU College of Medicine since 1955, is also professor of surgery and director of the Center for Continuing Medical Education. In addition, he is president of the Columbus Surgical Society, a diplomate of the American Board of Surgery, and holds membership in many professional organizations, including the OSMA and the AMA.

Governor James A. Rhodes posthumously honored Dr. Dean Sheldon, late of Sandusky, by naming him to the Ohio Conservation Hall of Fame. Dr. Sheldon was cited particularly for development of a tract of land in the Huron area which was used as a wildlife preserve and made available to nature study groups, scout outings, etc.

Dr. William A. Altemeier, professor and director of the Department of Surgery, University of Cincinnati, was elected a vice-president of the Pan-Pacific Surgical Association during the triennial congress of the organization in Honolulu. He also is president of the American Surgical Association.

HEAR IT LIKE IT IS...
Get the Inside Report

THE POLITICAL RACES . . . ON WHAT'S COOKIN' IN CONGRESS

supporter of the Ohio Medical Political Action Committee and the American Medical cal Action Committee, you'll want to attend the . . .



ANNUAL OMPAC LUNCHEON

WEDNESDAY, MAY 13, 1970

(Week of the OSMA Annual Meeting)

Second Floor

Sheraton-Columbus Hotel

Speaker . . .

Washington Columnist and Political Analyst

ROBERT D. NOVAK

Some facts about Mr. Novak . . .

In 1957, the Associated Press named him Capitol Hill correspondent in Washington, D.C. He joined the Wall Street Journal in 1958 as Senate correspondent and political reporter, and in 1961 became chief Congressional correspondent for the Journal.

y 1963, Mr. Novak teamed with Mr. Rowland Evans, Jr. to write INSIDE REPORT, a political column, ned five times a week. It is noted for its emphasis on reporting rather than punditry, and its rapidly g dateline.

OMPAC LUNCHEON RESERVATION

WEDNESDAY, MAY 13, 1970 — 11:30 A.M.

ed is $_____ to pay for:

___ OMPAC Luncheon tickets @ $5.00 per person

_____

Address: _____

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(Please pick up tickets at OSMA Registration Desk)

t: **Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215**

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COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter

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Asheville, North Carolina

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities within 85 acres of landscaped and wooded grounds in the City of Asheville.

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Contact: (1) Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions
or
(2) Samuel N. Workman, M.D.
Chief of Clinical Services

(3) Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry
and Medical Director

Area Code 704-254-3201

A MESSAGE FROM

Your OSMA President



AT THE RECENT WORKSHOP of the American Medical Political Action Committee in Washington, D.C., which I was privileged to attend, Senators Scott, Mansfield, and Guerney all stressed the importance of physicians actively participating in politics. They complimented the PAC movement for the good work it is doing and commended it for the stimulus it is giving physicians to take more aggressive interest in the affairs of government.

This is a critical election year, and I urge each of you as physicians, but more especially as citizens, to participate in the coming political campaigns and to help elect candidates of your choice.

Furthermore, I urge you, if you have not already done so, to make your contribution to the Ohio Medical Political Action Committee. By doing so you join your colleagues in Ohio and throughout the country in helping to elect to the Ohio Legislature and to the Congress qualified candidates who will reflect medicine's point of view in our lawmaking bodies.

Unfortunately, contributions to OMPAC this year have not come up to expectations, as indicated in the tabulation by counties in this issue of *The Journal*. We must bring membership up considerably if OMPAC is to do the effective job we would like to see.

Here are three key reasons why you should make your contribution to OMPAC-AMPAC:

1. 1970 is an election year of even greater importance than usual because the Ohio General Assembly, elected this year, will reapportion Congressional Districts and General Assembly Districts on the basis of the 1970 census.

2. Medicine will need all the Congressional friends it can muster to influence the development of proposed systems for the delivery and financing of health care. There is no doubt that this subject will be considered by the next Congress of the United States.

3. When you give to OMPAC your contribution is identified with your profession. Your gift helps make it possible for well qualified candidates to seek public office and to be elected with the support of the medical profession.

Remember, if medicine's voice is to be heard in the law-making bodies of the State and Nation, it must first be heard in the campaigns that create the Legislature and the Congress. Changes in the practice of medicine and in our health care systems are inevitable and desirable, but responsibility lies with the doctors to see that those changes are for the better.

Let your voice be heard through OMPAC-AMPAC. If you have not made your contribution, do so now. Make your contribution to your County Medical Society treasurer, or mail it to the Ohio Medical Political Action Committee, P.O. Box 5617, Columbus, Ohio 43221.

Robert N. Smith, M.D.

Robert N. Smith, M.D., President
The Ohio State Medical Association

ON THE OMPAC FRONT

Interesting Boxscores Kept on Congressional Voting

Just in case you missed this report in your local newspaper, for your perusal is the following dispatch from the *Columbus Citizen-Journal* Washington, D.C. Bureau, boxscoring the voting records of 16 Ohio Congressmen during the 1969 session of the Congress:

The Americans for Democratic Action (ADA) the liberal organization which keeps tabs on the voting records of Congress, found only one "perfect" pupil in the Ohio delegation — Cleveland Rep. Louis M. Stokes.

Stokes, the freshman Negro Democrat, scored 100 on the ADA scale for voting "right" on 15 votes which the ADA says separates liberals from conservatives.

Even Senator Stephen M. Young, considered one of the staunch liberals in the upper chamber, failed to get a perfect score by registering 94 on the ADA meter which was based on 18 roll call votes.

The ADA gave a surprisingly low score of 61 to freshman Republican Sen. William B. Saxbe, considered among the more liberal Republicans in the Senate.

Following Stokes in the House was Cleveland Rep. Charles A. Vanik, who scored 87.

Rep. Michael A. Feighan (D.-Cleveland) scored 60, Rep. Thomas L. Ashley (D.-Toledo) scored 73, Rep. William J. Stanton (R.-Painesville) 27, and Rep. William Minshall (R.-Cleveland), seven points.

Columbus Rep. Samuel L. Devine kept his conservative image by voting against every measure considered important to the ADA. He received a "zero" score for his effort.

Rep. Chalmers P. Wylie (R.-Columbus) scored seven points, as did Reps. Jackson Betts (R.-Findlay) and Clarence Miller (R.-Lancaster).

Cincinnati Rep. Robert Taft Jr. scored 33 and his Republican colleague, Rep. Donald D. Clancy scored seven points.

Rep. William H. Harsha (R.-Portsmouth) scored 13 and Rep. D. E. (Buz) Lukens (R.-Middletown) scored eight points.

Newspaper Selection Honors Resident Physician

The Columbus *Citizen-Journal* named a Columbus resident physician as one of its top ten men of the year. It saluted the ten men "for their deeds during the previous year" which reflected "an extraordinary concern for the well-being of their fellow man."

The following citation was published in the paper:

Dr. Randall L. Braddom — A resident physician at University Hospital, Dr. Braddom, 27, started what he calls "a Christian love project" that so far has furnished free physical examinations to about 400 members of the Neighborhood Youth Corps who could not otherwise afford the exams. Dr. Braddom enlisted a small army of other medically-oriented people interested in giving their time and skill to others. When the C-J discovered Dr. Braddom he almost didn't mention he did have a small problem—scant facilities to conduct the examinations. Since then the Columbus Academy of Medicine has assigned an officer to work as liaison with him. But Dr. Braddom didn't stop with all this. He has huddled with Columbus school officials about strengthening the emphasis of proper nutrition in school health courses. He also has approached Dr. William Brown, head of the city board of health to help in follow-up examinations of the youths, and he says he would like to do still more.

Speakers on Drug Abuse Urgently Needed

Realizing the deeper medical aspects of drug abuse, Ohio residents are flooding the Ohio State Medical Association office with requests for physician speakers at PTA meetings, church groups, school assemblies, etc.

So far, a limited number of physicians, mostly in the major urban centers, have volunteered their spare hours to meet these requests. Physician speakers are desperately needed, especially in Ohio's nonmetropolitan areas, to carry medicine's message on drug abuse to what is obviously an information-hungry public.

The OSMA office will provide speakers' packets which include sample talks as well as valuable resource materials, including pamphlets for audience distribution.

Physicians who wish to volunteer their services in this vital community effort are urged to write: Secretary, Committee on Mental Health, Ohio State Medical Association, 17 South High Street, Suite 500, Columbus 43215: or phone (614) 228-6971.


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Watch Your Prescribing Policy, Doctor Addicts May Be Abusing It

Doctor, after you prescribe amphetamines for an overweight patient — and his weight reaches a satisfactory level — what becomes of any extra drugs from that prescription? Could you have overprescribed?

Questions of this nature were discussed by the OSMA Committee on School Health during a recent meeting. This Committee and the OSMA Committee on Mental Health are continually seeking more effective methods of combatting the ever-growing menace of drug abuse.

"Physicians often contribute unintentionally to drug abuse by overprescribing and, in general, not carefully checking the flow of narcotic drugs to their patients," said Charles H. McMullen, M.D., of Loudonville, chairman of the Committee on School Health.

Dr. McMullen recommended that physicians read handy tips on narcotic dispensing compiled by the Federal Bureau of Narcotics and released by the American Medical Association. They are as follows:

1. **Don't** leave prescription pads around. Addicts may be forgers.

2. **Don't** write a narcotic prescription in lead pencil, or any Rx at all in pencil as they may be changed to call for morphine.

3. **Don't** write narcotics as "Morphine HT ½ X" or "Morphine HT ¼ #10."

4. **Don't** carry a large stock of narcotics in your bag. Addicts are often watching M.D.s' offices and cars.

5. **Don't** store your office narcotic supply unprotected, especially near a sink or washroom; patients may ask to use these facilities.

6. **Don't** fall for a story from a stranger claiming an ailment that usually requires morphine. The addict can produce blood sputum, simulate bad coughs or other symptoms. Make your own diagnosis.

7. **Don't** give an Rx to anyone except the actual patient. Addicts have posed as nurses.

8. **Don't** write for large quantities of narcotics unless unavoidable. Diversion to addicts is profitable, as much as $1 for ¼ grain M.S.

9. **Don't** prescribe narcotics on the story that another physician has been doing so. Consult that physician or hospital records.

10. **Don't** leave Rx's signed in blank for nurses to fill in. Many have been stolen by addicts.

11. **Don't** treat an ambulatory addict. Addicts must be under proper control. Many go to several physicians at one time.

12. **Don't** dispense narcotics without keeping records, although bedside and office administration is permissible.

13. **Don't** buy your office narcotic needs on an Rx blank. The law requires that you use an official order form.

14. **Don't** resent a pharmacist's call for verification of an Rx. He is held responsible if forgeries are filled.

15. **Don't** hesitate to call an agent of the Federal Bureau of Narcotics (at your nearest Federal Building) or the Narcotics Division of your State Department of Health if the patient is suspect. Your information will be held in strict confidence.

16. **Don't** phone in a Class A Narcotic Rx except in true emergencies. Even then the pharmacist must have a written prescription in his or his agent's hand before he can make delivery to your patient. The pharmacist or his agent may pick up the Rx at your office or at the home before making delivery.

Violations of this section of the narcotic law may entail two to ten years imprisonment and up to a $20,000 fine for the first offense. Second and third violations are more severe.

Opinion of the Attorney General

Following is the syllabus of Opinion No. 70-004 given by Attorney General Paul W. Brown and dated January 21, 1970:

"The office of county commissioner is not compatible with the office of part-time health commissioner of a city health district."



Remember how great milk of magnesia tasted?

Almost as good as castor oil.
But now you can spare the taste buds and spoil the patient with a modern Dulcolax tablet or suppository.

And Dulcolax works so predictably that the time of bowel movement can often be predicted. Tablets taken at night usually produce a bowel movement the following morning. Suppositories generally work in 15 minutes to an hour.

For preoperative preparation, a combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly.

Dulcolax suppositories may be particularly helpful when straining should be avoided, as in postoperative care. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

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A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



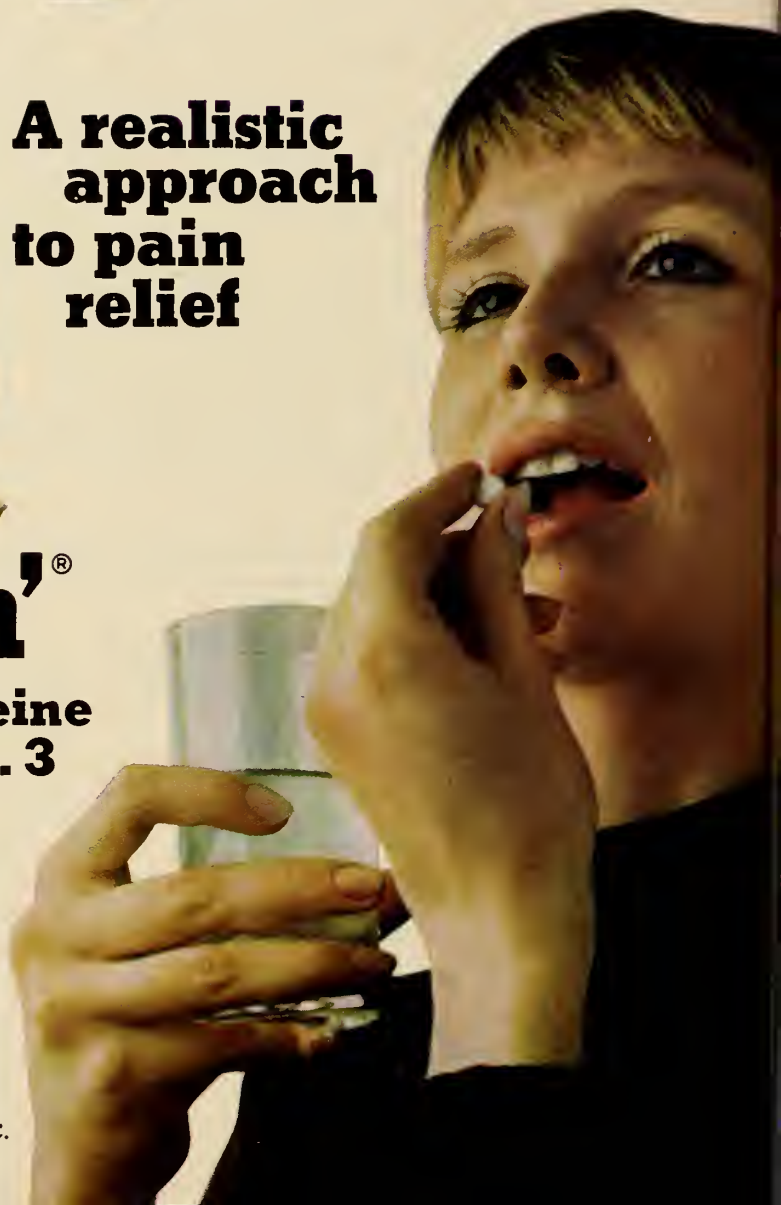


The pain of earache was allegedly reli
by holding a hot roasted onion to the e

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



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Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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First choice

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When ephedrine is too exciting or is contraindicated

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During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2
A counterpart for Mudrane-2

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For pediatric use or where liquids are preferred

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86% greater risk of angina pectoris,
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71% greater risk of coronary heart disease.*
Obesity may also aggravate osteoarthritis,
flat feet, intertriginous dermatitis, varicose
veins, and ventral or diaphragmatic hernias.[1-3]

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Preludin®

phenmetrazine hydrochloride
Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by mid-morning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.

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PR-7169



Investment Prognosis

By Frank Van Holte, Columbus

ADMITTING THAT WE HAVE a strong tendency to look for favorable news, there now appears to be a number of cracks in the long bear market. We suddenly have a strong bond market and I believe the interest rate cycle has peaked. We have seen a sharp drop from the very high interest rates on both taxable and nontaxable bonds. Of course, we don't expect a retreat to 6 percent or 7 percent rates on corporate bonds, for instance, in the immediate future, but the high yields of this bear market are apparently past.

Another interesting factor has been a rising trend in the number of new highs of common stocks and a decline in the trend in the number of new lows. This change began appearing soon after the first of the year and suggests a strengthening of the market, and perhaps this crack will widen into a more sizable break in the bear market. Of course I am not suggesting that we will swing quickly into a bull market. I am suggesting again that we may have to wait a long time to have the buying opportunities that we have today.

This situation reminds me of the intense desire we have each year in the end of the winter months, to see the first signs of spring. The signs are always slow in coming, and then suddenly it is summer. I believe the springtime signs of a bull market are appearing.

What to buy? The oils look very attractive and, as I mentioned in the column last month, "Mobil Oil" is particularly appealing, although there are many good companies in this industry and many are selling at very low price/earning ratios. The utilities should not be ignored. Look at Columbus and Southern Ohio Electric, Cincinnati Gas & Electric, or Cleveland Electric Illuminating. These stocks not only offer a handsome yield, but they also offer an excellent oportunity for capital appreciation. These companies are growing and they certainly offer the conservative investor an opportunity to buy at good prices.

If your tax bracket is high, I still recommend that you look at municipal tax-free bonds. Although yields on these bonds are down somewhat from the bear-market high, they still represent a means of reducing your current taxes, and they also offer the opportunity for long term capital gains.

There are many other good buys in the market at this time. Discuss with your broker your investment ideals and I'm sure he will recommend issues that can be purchased at bear bottom lows, so that you can ride along with the tide of a new bull market.

I have noticed a renewal of interest in mutual funds. Many of the recent buyers are simply adding to their investment in funds because prices are so low and they are lowering their average cost per share. But there also are a number of investors buying mutual funds as initial investments. In today's busy world, we cannot overlook the fact that mutual funds offer the investor the means of investing small sums of money regularly with a minimum of worry, inconvenience, security analysis, and time consumption. Mutual funds are an excellent **long range** investments and I'm sure you could not buy at a better time than today.

We have a tendency to think that the current decline in stock prices is the deepest decline in recent history. The drop in price in the past year of some of the stocks we own seems to support this thinking. Although the present decline which began in December, 1968, is the longest decline in the post World War II period, it is not the largest. The current decline in the Dow Averages is about 25 percent. The Dow Averages declined 27 percent in the December '61 to June '62 slide, and the 1966 decline also fell off 25 percent. In fact, the Dow Averages show 10 declines since 1946. So I offer you this bit of history, not only to suggest that you seriously consider investing in securities while the stock averages are on the bottom rung of the ladder, but also to encourage you to "hold on" if your investments were made on a much higher rung of the ladder. "We Shall Return," I'm sure.

This monthly feature is written exclusively for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

OMPAC and the '70 Elections

Your Membership in the PAC May Be the Key To Better Qualified Lawmakers

THIS YEAR marks another of those crucial periods in the political arena—a period climaxing with the General Elections in November. Don't take your franchise for granted. You may not "lose" it, but you may have your vote overwhelmed by a vocal and aggressive minority opposition.

Join forces now with your colleagues through the Ohio Medical Political Action Committee and help elect Ohio legislators and U. S. Congressmen who will reflect your thinking in the law-making bodies of the land.

Memberships in OMPAC have been coming in well through the first two months of 1970, but many more memberships are needed if OMPAC is to be an effective force in Ohio. Dr. Frank H. Mayfield, of Cincinnati, OMPAC chairman, urges all Ohio physicians to consider seriously the work of OMPAC and to help support its activities.

Physicians who have not made their 1970 contribution to OMPAC and AMPAC are urged to do so through their county medical society treasurers.

Following are figures by district and by county indicating the number of physicians who have made their contributions to OMPAC as of March 1, compared with the number of Ohio State Medical Association members in the respective areas.

First District	OSMA	OMPAC
Adams	9	6
Brown	16	0
Butler	200	63
Clermont	18	3
Clinton	19	4
Hamilton	1300	336
Highland	18	1
Warren	14	0
	1594	413
Second District		
Champaign	14	5
Clark	131	42
Darke	25	0
Greene	56	0
Miami	65	25
Montgomery	599	173
Preble	6	1
Shelby	23	16
	919	262
Third District		
Allen	134	60
Auglaize	16	2
Crawford	41	19
Hancock	45	10
Hardin	28	0
Logan	15	1
Marion	69	13
Mercer	19	0
Seneca	40	12
Van Wert	19	5
Wyandot	10	3
	436	124
Fourth District		
Defiance	25	18
Fulton	16	3
Henry	12	0
Lucas	639	44
Ottawa	20	8
Paulding	8	0
Putnam	11	4
Sandusky	47	7
Williams	18	0
Wood	39	3
	835	87

Fifth District	OSMA	OMPAC
Ashtabula	58	3
Cuyahoga	2287	97
Geauga	29	15
Lake	112	54
	2486	169
Sixth District		
Columbiana	70	7
Mahoning	343	105
Portage	61	13
Stark	347	129
Summit	587	41
Trumbull	137	0
	1545	295
Seventh District		
Belmont	57	17
Carroll	9	3
Coshocton	21	0
Harrison	7	6
Jefferson	73	1
Monroe	3	0
Tuscarawas	49	15
	219	42
Eighth District		
Athens	42	0
Fairfield	50	16
Guernsey	25	0
Licking	69	14
Morgan	3	0
Muskingum	75	37
Noble	2	0
Perry	7	2
Washington	32	0
	305	69
Ninth District		
Gallia	39	7
Hocking	9	0
Jackson	14	0
Lawrence	23	11
Meigs	6	0
Pike	6	0
Scioto	66	19
Vinton	1	0
	164	37

(Continued on Next Page)

(OMPAC—Continued)

Tenth District	OSMA	OMPAC
Delaware	25	4
Fayette	15	6
Franklin	972	245
Knox	37	15
Madison	13	3
Morrow	7	5
Pickaway	22	9
Ross	39	28
Union	16	0
	1146	315
Eleventh District		
Ashland	26	7
Erie	63	25
Holmes	10	4
Huron	30	16
Lorain	212	49
Medina	57	15
Richland	123	0
Wayne	66	24
	587	140
Totals	10,236	1953

Physician Named to New Hearing Aid Board

Governor James A. Rhodes recently announced the appointment of Raymond L. Pfister, M.D., professor of otolaryngology at the University of Cincinnati, as the otolaryngologist member of the newly created Hearing Aid Dealers and Fitters Licensing Board.

The five-member board was created under provisions of S.B. 61 passed by the Ohio General Assembly last year to become effective November 25, 1969. The law calls for three members to be currently engaged in the practice of dealing in and fitting hearing aids, one to be an otolaryngologist and one a clinical audiologist.

Emmett W. Arnold, M.D., as director of the Ohio Department of Health, automatically serves as an ex-officio member of the board.

Dr. Pfister's term is for three years. Other members of the board are Robert Temmermen, Toledo (two-year term); John W. Sproat, Columbus (three years); and Richard L. Clark, Cleveland Heights (four years), all hearing aid dealers; and Kenneth W. Berger, director of the Speech and Hearing Clinic at Kent State University (four-year term). After the expiration of present terms, all terms will be for four years.

Dr. Pfister is a practicing otolaryngologist in Cincinnati and a diplomate of the American Board of Otolaryngology. Among professional affiliations, he is a member of the Ohio State Medical Association and the American Medical Association.

Medical Library School Seeks Masters Candidates

In recognition of the demand for trained personnel, a training program in medical librarianship and communication in the health sciences has been initiated by the School of Library Science of Case Western Reserve University with support from the U.S. Public Health Service through the Extramural Program of the National Library of Medicine. This program provides an integrated sequence of specialized courses in medical librarianship and communication within the School's one-year Master of Science in Library Science curriculum. Graduates are eligible for certification by the Medical Library Association.

Ten stipends of $2,400, plus dependency allowance and full payment of fees, are available for 1970-71 to selected applicants of excellence and promise, but enrollment in the program is not limited to recipients of stipends. For other financial aid, see the Library School catalog. Ample opportunity for part-time employment is available in the many libraries in the University Circle area and throughout Greater Cleveland.

Persons interested in more information should write: Professor Alan M. Rees, Director, Training Program in Medical Librarianship, 10831 Magnolia Drive, Cleveland, Ohio 44106.

Physician's Bookshelf

Preparation for the Study of Medicine, edited by Robert G. Page, M.D., Toledo, and Mary H. Littlemeyer; *University of Chicago Press ($4.95).* The University of Chicago and the Association of American Medical Colleges sponsored a conference on the Optimal Preparation for the Study of Medicine, which was held at The University of Chicago. Essentially, this book is a collection of papers which were originally presented at that conference. The contributors —most of whom are university administrators, professors, and deans of medical schools—are concerned with those aspects of medical education which involve students preparing themselves for the study of medicine.

Dr. Page is dean and professor of medicine, Medical College of Ohio at Toledo. He was previously associate professor of medicine and associate dean, Division of Biological Sciences, at the University of Chicago. Mary Littlemeyer is senior staff associate, the Association of American Medical Colleges.

ADDENDUM TO PREVIOUS PRINTING OF

Proposed Revisions in the Constitution and Bylaws of the OSMA

In the printed version of the Proposed Revisions in the Constitution and Bylaws of the Ohio State Medical Association which appeared in the March issue of *The Journal,* pages 290, etc., inadvertently a part of the proposed Bylaws was omitted, namely the last part of Chapter 14 and all of Chapters 15 and 16. To supply readers with the omitted text, proposed Chapters 14, 15, and 16 are included below.

CHAPTER 14

REFERENDUM

Within sixty (60) days after a general referendum has been ordered either by the (1) House of Delegates, or (2) upon the petition of at least thirty (30) component societies as prescribed in Article X of the Constitution, the Executive Director shall prepare and have printed and mailed by first-class mail to each Active Member of this Association an official circular setting forth the following:

(a) A resume of the provisions in this Constitution and Bylaws applying to a general referendum;

(b) An announcement by the President as to the time set by him for closing the polls which shall be not less than fifteen (15) days nor more than thirty (30) days after the mailing of circulars and ballots;

(c) The resolution, motion or action submitted to referendum;

(d) A statement of not more than 200 words prepared by the proposer or proposers of the resolution, motion or action giving arguments in its favor;

(e) A statement of not more than 200 words giving arguments in opposition prepared by one or more members appointed by the President from among those opposed to the resolution, motion or action.

Enclosed with the circular shall be an official reply envelope and a ballot labeled with the official seal of this Association. On the ballot the resolution, motion or action shall be printed and below it shall be spaces for the indication of "yes" or "no" by making a cross mark. The reply envelope shall be addressed to a special committee of three tellers appointed by the President and it shall carry return first-class postage or the equivalent thereof under the postal regulations.

To be counted by the tellers a ballot shall meet the following requirements:

(a) Either "yes" or "no" must be clearly indicated with a cross mark;

(b) The ballot must be received by the committee of tellers in the sealed official reply envelope by first-class postage on or before the day set for closing the polls; and

(c) The ballot must be an official ballot mailed to each Active Member, duly labeled with the seal of this Association.

Within ten days following the time set for closing the polls, the tellers shall meet at the headquarters office of this Association to open the envelopes containing the ballots and poll the votes in the presence of each other, keeping in mind that the referendum is not valid unless participated in by not less than one-half of the Active Members of this Association.

The results of the referendum shall be transmitted in writing by the tellers to the President immediately after the count has been completed. The President shall announce such results to the members of the Council and publication thereof shall be made in *The Journal* of this Association.

Except as otherwise provided in Article X of the Constitution of this Association, a resolution, motion or action receiving a majority of the votes cast in a valid referendum, shall be declared adopted, carried or ratified, as the case may be, and the same shall become effective fifteen (15) days after the results of the referendum shall have been published in *The Journal.*

CHAPTER 15

AMENDMENTS

Section 1. Method of Amending. These Bylaws may be amended at any Annual Meeting of the House of Delegates by a majority vote of the delegates present at that session, provided that the proposed amendment shall have been published in *The Journal* at least thirty (30) days prior to the Annual Meeting.

Section 2. Conformity by Component Societies. When an amendment of these Bylaws has been adopted as provided in Section 1 hereof, it shall be the duty of the Executive Director to notify the secretary of each component society within sixty (60) days after such amendment has become effective. It shall become incumbent upon each component society to make such changes in its constitution and bylaws, or, if the society be a corporation, in its articles of incorporation, code of regulations, code of bylaws, or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the Bylaws of this Association.

Within one hundred and eighty (180) days after such notification to each component society, written notice of compliance by such component society with this provision, together with copies of the changes made to effect such compliance, shall be sent by the secretary of such component society to the Council for its review and approval.

CHAPTER 16

Upon the adoption of these Bylaws, all previous Bylaws are hereby declared null, void and of no effect.

(Please Turn Page)

Proposed Amendment To OSMA Bylaws

Under provisions of Chapter 15, Section 1 of the OSMA Bylaws, the text of a Resolution proposing an amendment to the Bylaws is printed herewith. The Resolution was received at the OSMA headquarters office before March 12, thereby meeting the deadline specified under Chapter 4, Section 8 of the Bylaws.

RESOLUTION

OSMA Membership for Doctors of Osteopathic Medicine and Surgery

(Cleveland Academy of Medicine)

WHEREAS, The House of Delegates of the American Medical Association has voted to ". . . Provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine," and

WHEREAS, The House has also suggested that . . . "each county and state medical society may accept qualified doctors of osteopathic medicine and surgery as active members and thereby provide for their membership in the American Medical Association,"

THEREFORE, BE IT RESOLVED, That the By-laws of the Ohio State Medical Association be amended by adding the phrase "doctor of osteopathic medicine and surgery" to paragraph (c), Section 4 Eligibility, of Chapter 1 Membership so that it will read (portion to be added is underlined):

"He must hold the degree of doctor of medicine or some foreign degree in medicine regarded by the Council of the Ohio State Medical Association as equivalent thereto, or doctor of osteopathic medicine and surgery."

HONORED BY LOUDONVILLE JAYCEES

Physician Wins Distinguished Service Award

Adapted from Feature Article in the *Ashland Times-Gazette*

The Distinguished Service Award banquet of the Loudonville Jaycees held Saturday evening (Feb. 7) at Wally Camp pavilion brought into focus three areas of outstanding service to the community.

Dr. Charles H. McMullen was awarded the coveted Distinguished Service Award plaque for his faithful service to civic, educational, fraternal and professional organizations.

The Loudonville Emergency Squad, division of the Loudonville Volunteer Fire Department, received recognition for its valuable aid to the community.

Gov. James A. Rhodes, as guest speaker for the event, brought to the diners a forthright message on education, welfare, and opportunity for youth.

Preceding the awards presentation, master of ceremonies Alan Scheaffer, local attorney, recognized many local personalities of the area who were in attendance. William Kiefer, president of the Loudonville Jaycees, gave a review of activities sponsored by the 28 young men between the ages of 21 and 35 who make up the local civic organization.

During the awards presentation, as Scheaffer summarized the background of the DSA recipient, a delighted note of recognition came from the crowd as they realized the winner was Dr. McMullen.

In accepting this very special award, Dr. McMullen credited his wife and family for their help and expressed his warm feelings for the people of Loudonville. Summing up his philosophy of life, he quoted a passage by John Donne:

"No man is an island unto himself . . ."

In making the presentation, Schaeffer read the following account of Dr. McMullen: Born July 24, 1923 in Polk, Ohio. Charles Harsha McMullen moved to Loudonville in 1929 where he attended Loudonville Public Schools until his graduation in 1941.



(Photo courtesy Ashland Times-Gazette)
Dr. McMullen accepts Distinguished Service Award plaque at Loudonville Jaycees banquet.

His leadership ability was quite evident during this time as he played four years of varsity basketball, was a member of the band and orchestra, member and accompanist of the choir, president of Junior and Senior Honor Societies, president of the Student Council and president of his senior class.

He attended Ohio State University until 1943 and during that time enlisted in the Reserve Corps of the Army as a member of the student training program. He married his high school sweetheart, Miss Genevieve Critchfield, during his college years.

After furthering his education at the University of New Hampshire, Hamilton College and Long Island College of Medicine, he returned to Ohio State University College of Medicine, where he received his degree as a doctor of medicine in 1950. In the meantime, two daughters were born to the McMullens,

Pamela in 1946 and Cynthia in 1948.

After completing his internship at the University of Cincinnati, he again served his country as a flight surgeon with the rank of captain. In 1953, the McMullens returned to Loudonville to take up residence.

While serving the community as a general practitioner, Dr. McMullen also found time to give his service to professional, community, educational, and fraternal organizations, as well as to his family, which by this time had another addition, a son John in 1959.

Besides his professional affiliations, Dr. McMullen has been an active member of the American Legion, Masons, Shriners, and Rotary, and a past member of the Red Cross board. He serves as a member of the executive board of the Johnny Appleseed Area Boy Scout Council, and since 1966 as a member of the Board of Education of the Loudonville-Perrysville Exempted Village School District, of which he now serves as president.

In addition, Dr. McMullen has been a stemwinder in medical organization work. In the Ashland County Medical Society he has held all offices, including that of president. He has served as an alternate delegate to the OSMA House of Delegates and sat as a delegate for his society. He is chairman of the OSMA Committee on School Health and has served as a speaker in the "When You Begin Practice" series for medical students. He is also a member of the Joint Committee on Athletic Injuries sponsored by the OSMA and the Ohio High School Athletic Association.

He is a member of the AMA and was a speaker for the AMA's 1969 National Conference for Physicians and Schools. He also represented the AMA on the AMA-National Education Association Joint Committee on Health Problems in Education. He is a member of the Ohio Academy of General Practice and the AAGP, plus numerous other organizations.

Poison Information Center Reports on Operation

A summary of the eleventh year of operation of the Community Hospital Poison Information Center, associated with the Community Hospital of Springfield and Clark County, gives interesting data on patients treated at a typical center.

Of 531 patients involved in the operation during the year, 386 were under 5 years of age; 26 were 6-15 years; 71 were in the 16-30 age group; 32 from 31 to 55; and 5 were from 56 to 71. Ages of four adults and seven children were unknown.

In the nature of incidents, 83.42 percent were accidental, and 16.58 percent were presumed intentional.

Of the 531 patients involved, there was 100 percent recovery.

In the disposition of patients, 26 were admitted to Community Hospital; 289 were examined and/or treated and released; 202 involved calls for information only; 4 calls about patients were from physicians; and 10 were admitted to other hospitals.

A variety of causative agents were involved. Following are the number of times a causative agent was involved, and since a number of patients were involved with two or more agents, the total of agents does not correspond with the total of patients:

Aspirin and aspirin compounds, 132; other analgesics, 13; hypnotics and sedatives, 34; antihistamines, 10; laxatives, 14; cough medicines, 8; tranquilizers, 44; vitamins, 40; others (internal), 57; unknown (internal), 9; antiseptics (external), 3; liniments, 3; others (external), 15; soaps and detergents, 4; disinfectants, 6; bleaches and other corrosives, 24; furniture polish, 2; other (household preparations), 12; petroleum distillates, 24; cosmetics, 22; pesticides, 20; paints, varnishes, and solvents, 8; miscellaneous agents, 37; plants, 21; gases, fumes, and inhalants, 8; topical contact of skin or mucous membranes, 9.

Cincinnati Student Among Recipients of Scholarships

Medical scholarships, averaging $8,000 each, were awarded in January to 12 black college students to help finance their medical education. The grants were announced by the National Medical-Sloan Scholarships, administered by the National Medical Fellowships, Inc.

Since 1960, over $700,000 in scholarships have enabled 102 black students to complete their medical education. The funds are provided by the Alfred P. Sloan Foundation.

Among the latest recipients of the scholarships was Lonnie C. Jenkins, University of Cincinnati.

For information on this and other assistance programs offered for black students, write to National Medical Fellowships, Inc., 3935 Elm Street, Downers Grove, Illinois 60515.

Obituaries

Roberto Agraz, M.D., Willoughby; Faculty of Medicine, National University of Mexico, 1945; aged 49; died February 7; member of the Ohio State Medical Association and the American Medical Association; native of Mexico; general practitioner in the Willoughby area for about eight years, and previously associated with the St. Margaret Hospital in Dorchester, Mass.; last rites from the Catholic Church; survived by his widow, two sons, three sisters, and a brother.

Walter Waldo Beck, M.D., St. Petersburg, Fla.; Ohio State University College of Medicine, 1917; aged 77; died February 12; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; living in retirement recently; former physician and surgeon of long standing in Toledo; veteran of World War I; survived by his widow, a daughter, and two sisters.

John Fletcher Boettner, M.D., Cleveland; Western Reserve University School of Medicine, 1926; aged 70; died February 19; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; general practitioner of some 42 years' standing in Cleveland; served on the board of the YMCA; past president of the South East Cleveland Kiwanis Club; member of the Masonic Lodge and the Church of Christ; veteran of World War II; survived by his widow, a son, Dr. Robert B. Boettner, three daughters, and a brother.

Rundle Donald Campbell, M.D., Mansfield; Rush Medical College, 1934; aged 64; died January 16; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, and the American Society of Abdominal Surgeons; past president of the Richland County Medical Society; physician and surgeon in Mansfield for about 35 years; member of the Congregational Church, the Fifty-One Club, several Masonic bodies, and the Elks Lodge; veteran of World War II; survived by his widow, two sons, and a sister.

Albert James Fisher, M.D., Albuquerque, N.M.; Western Reserve University School of Medicine, 1937; aged 57; died January 30; former member of the Ohio State Medical Association; formerly practiced in Youngstown and in Cleveland before leaving to practice in New Mexico about 1955; specialized in anesthesiology; diplomate of the American Board of Anesthesiology; member of the American Society of Anesthesiologists and the International Anesthesia Research Society; survived by his widow, two daughters, a brother, Dr. Marion G. Fisher, of Oberlin; also a half-brother.

Hugo Hecht, M.D., Cleveland; medical degree from the University of Prague, 1906; aged 86; died February 1; member of the Ohio State Medical Association and the American Medical Association; resident of this country since 1938 and practitioner for many years in Cleveland where he specialized in dermatology; author of numerous scientific papers; honored with a citation by the International Congress on Dermatology in 1962; member of the Masonic Lodge; survived by his widow, a son, a step-son, and a step-daughter.

David L. Hirst, M.D., Miamisburg; University of Cincinnati College of Medicine, 1934; aged 62; died February 5; member of the Ohio State Medical Association and the American Medical Association; practitioner in Miamisburg from 1935 until 1962, and later physician for the Lebanon Correctional Institute; survived by his widow, two daughters, two sons, three sisters, and a brother.

Lloyd Leggett Hoskins, M.D., Ft. Lauderdale, Fla.; University of Cincinnati College of Medicine, 1919; aged 77; died January 12; former member of the Ohio State Medical Association; diplomate of the American Board of Obstetrics and Gynecology; practitioner in Cleveland until his retirement about 1950.

Glenn Schroeder Lamkin, M.D., Sardinia; University of Cincinnati College of Medicine, 1933; aged 61; died February 16; member of the

Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; practitioner in Brown County for many years, with emphasis in EENT field as well as general practice; veteran of World War II; survived by his widow, a son, three daughters, and two sisters.

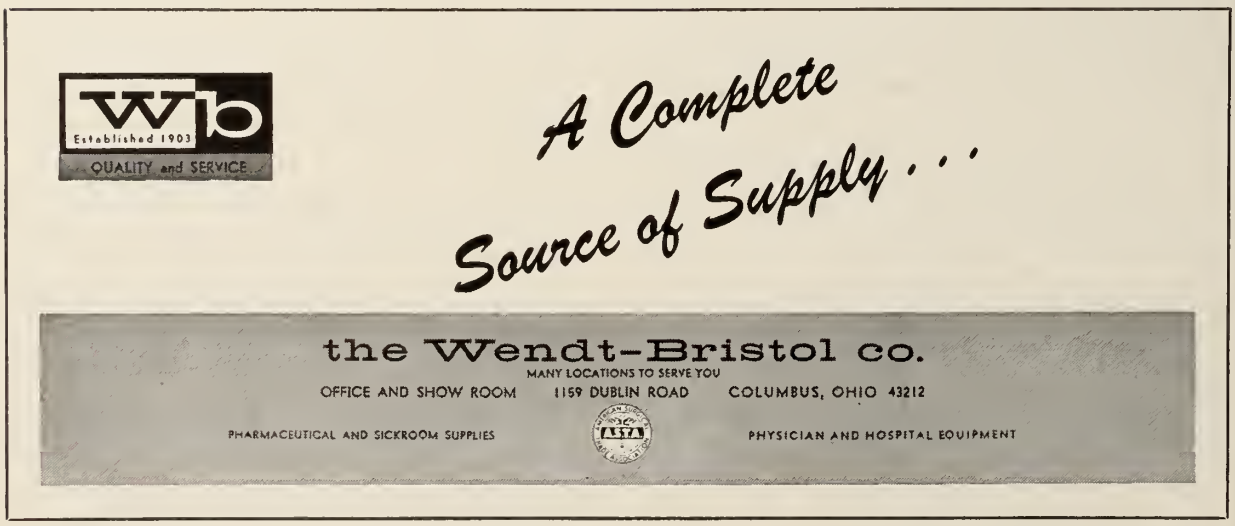
Homer W. McCreary, M.D., New Concord; University of Cincinnati College of Medicine, 1919; aged 79; died February 7; member of the Ohio State Medical Association, the American Medical Association, and the American Thoracic Society; Fellow of the American College of Chest Physicians; native Ohioan and practitioner in Saranac Lake, N.Y., for most of his professional career; resident of New Concord for about six years; member of the Presbyterian Church; survived by his widow, a daughter, a son, a sister, and two brothers.

Lizabeth Sara Mainzer, M.D., Mansfield; Faculty of Medicine, University of Basel, Switzerland, 1936; aged 58; died January 23; member of the Ohio State Medical Association and the American Medical Association; native of Germany; practitioner in Mansfield since about 1940, specializing in pediatrics; member of the Mayor's Committee on Human Relations, Fine Arts Guild, League of Women Voters, Colony Club, Women's Club; former member of the YWCA board; survived by her husband, Dr. Ernest B. Mainzer, a daughter, a son, a sister, and two brothers.

Samuel Addison Marable, M.D., Columbus; Vanderbilt University School of Medicine, 1952; aged 41; died February 21; member of the Ohio State Medical Association, the American Medical Association, and the American Association for Thoracic Surgery; Fellow of the American College of Surgeons; diplomate of the American Board of Thoracic Surgery and the American Board of Surgery; on the surgery faculty at Ohio State University; practicing surgeon in Columbus and active in medical organization work; president of the Academy of Medicine of Columbus and Franklin County at the time of his death; survived by his widow, two sons, three daughters, his father, and a brother.

Otto Karl Muhme, M.D., Toledo; Toledo Medical College, 1913; aged 81; died February 14; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Abdominal Surgeons; Fellow of the American College of Surgeons and the International College of Surgeons; lifelong resident of Toledo and practitioner there for about 55 years; also physician for the Norfolk & Western Railroad and member of the American Association of Railway Surgeons; member of the Masonic Lodge; survived by his widow, and a brother, Dr. Norman B. Muhme, also of Toledo.

James Louis Murphy, M.D., Fostoria; Eclectic Medical College, Cincinnati, 1929; aged 65; died January 18 in Florida; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, and the American Society of Abdominal Surgeons; practitioner of some 40 years' standing in the Fostoria area; outstanding civic leader; member of the Rotary Club and other local

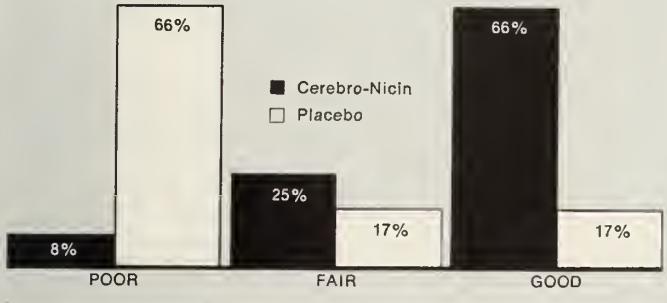


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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
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DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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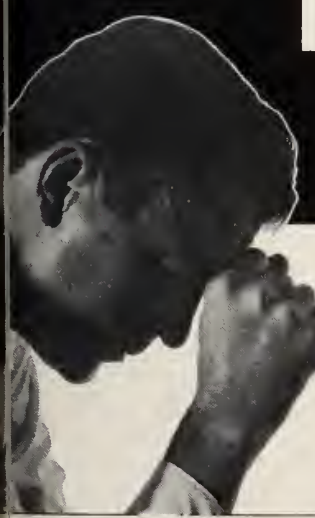
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NEW CLINICAL STUDY

in the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

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-thyl Testosterone ..2.5 mg.
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ailable:
ttles of 100, 500, 1000.

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Each red tablet contains:
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Thiamine HCL .....10 mg.
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Each white tablet contains:
Methyl Testosterone ..2.5 mg.
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Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
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Available: Bottles of 60, 500.

Contraindications—Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Dsol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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organizations; survived by his widow, two sons, and six sisters.

Foster Myers, M.D., Toledo; Western Reserve University School of Medicine, 1917; aged 79; died February 16; member of the Ohio State Medical Association and the American Medical Association; practitioner in Toledo for 50 years, specializing in internal medicine and hematology; past president of the Academy of Medicine of Toledo and Lucas County; veteran of World War I and a member of the American Legion; also member of the Unitarian Church; survived by a son, a daughter, and a brother.

Rudolph Joseph Pospisil, M.D., Springfield; University of Colorado School of Medicine, 1936; aged 59; died January 18; member of the Ohio State Medical Association and the American Medical Association; practitioner in Springfield for most of his professional career, specializing in pediatrics; member of the Lutheran Church, and the Elks Lodge; veteran of World War II; survived by his widow, two sons, a daughter, and a brother.

George Philip Sassos, M.D., Mt. Vernon, Georgia; medical degree from the University of Athens, Greece, 1958; aged 47; died February 4; former member of the Ohio State Medical Association; native of Pennsylvania; former resident at Aultman Hospital, Canton, and formerly associated with the Oak Hill Clinic in Jackson County; survived by his widow, a son, a daughter, three brothers, and a sister.

Jeanette Marie Troup, M.D., stationed in the Nigerian mission field; Hahnemann Medical College of Philadelphia, 1950; aged 46; died February 18; former resident of Akron and former intern and resident at Peoples Hospital, Akron; Akron General Hospital; and Children's Hospital, Akron; survived by her mother, two brothers, and a sister.

John Poag Tucker, M.D., Cleveland; Western Reserve University School of Medicine, 1916; aged 79; died January 29; member of the Ohio State Medical Association, the American Medical Association, and the Central Society for Clinical Research; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine; retired in recent years after a career of long standing in association with the Cleveland Clinic Hospital; veteran of World War I; former director of the Academy of Medicine of Cleveland; survived by his widow and a son.

Ten Rules for Avoiding Lawsuits

To reduce the number of doctors who appear in court as defendants, a Cleveland specialist in the defense of medical liability cases has offered some guidelines for medical practices. The following recommendations were presented by attorney R. Crawford Morris in the February, 1969 issue of *The Physician's Legal Brief* (and quoted here from the AMA Medical Staff-in-Action):

1. The physician can usually decline to accept a patient if he does so before he places himself in the position of abandoning the patient.
2. Never guarantee a cure.
3. Watch the time factor, especially if there has been an unfortunate result. This rule relates to the statute of limitations as they vary in each state.
4. Keep up with the advances in medicine. A physician will be judged by what is considered good medical care at the time he renders the treatment.
5. Do not use unnecessary experimental procedures. If an experimental procedure is deemed necessary, announce it as such, and obtain a written informed consent for the procedure.
6. Make a simple, reasonable disclosure of the risks involved, unless there is a therapeutic reason for not telling the patient. In these instances, tell the patient's relatives, but obtain an informed consent from the patient for everything done.
7. Keep good records.
8. Cooperate with the medical profession.
9. Do not be hesitant about consultation.
10. Maintain good public relations.

Dr. Robert H. Jebsen, professor and director of the Department of Physical Medicine and Rehabilitation, University of Cincinnati College of Medicine, has been elected for a second term as secretary-treasurer of the American Association of Electromyography and Electrodiagnosis.

Dr. David M. Creamer, Bellaire physician who served two tours overseas under the Volunteer Physicians for Vietnam program, described his experiences before the Bellaire Kiwanis Club and illustrated his talk with slides.

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

COLUMBUS IS THE SCENE of the annual auxiliary meeting in May, and part of that scene will be laid in the Governor's Mansion! Now is the time for action — who is the "social" secretary in your family? Doctors and wives, check your calendars to be sure the second week in May has a big circle around it. You will have to compromise on where to stay, but make your reservations right away. Headquarters for the OSMA convention is the Sheraton-Columbus, while the wives will hold most of their sessions at the Christopher Inn.

Auxilians, one and all — come to Columbus and join in "A Salute to Thirty Years." State officers and chairmen will need to arrive on Tuesday, May 12 for the pre-convention Board luncheon and meeting. You local officers, delegates, and alternates will find the two-day program on Wednesday, May 13 and Thursday, the 14th has much to spark your interest. There will be fun and relaxation as well as business. Delegates and alternates, of course, have an official responsibility for the morning business sessions each of the two days.

We urge as many **members** as possible to take a few days off from home and community responsibilities, come with your husbands to Columbus, and see what the convention has for you. Even if your husbands can't get away, you come, please! We need and want all of you.

Program Personalities

Columbus Mayor Maynard E. Sensenbrenner and OSMA President Robert N. Smith will welcome auxilians at the first business session of the convention on Wednesday morning, May 13. Mrs. R. C. L. Robertson, of Houston, Texas, president-elect of the Women's Auxiliary to the American Medical Association, will address the House of Delegates that first morning. Also the clock will turn back 30 years for a bird's eye view of the three decades of Ohio's auxiliary.

Birthday Tea at Governor's Mansion

A first in celebrations for us — Mrs. James A. Rhodes will be the official hostess for the Auxiliary's thirtieth birthday party on Wednesday afternoon. The party will honor our past state presidents. Not only will the birthday tea, complete with delectable refreshments, be held at the Governor's Mansion, but county presidents will give their annual reports there also. The tea is scheduled for 2:00 to 4:30 p.m. with the reports being given about 3:00. It sounds like a full but exciting day!

Two Joint Affairs

The OMPAC luncheon is scheduled for Wednesday noon at the Sheraton-Columbus Hotel. OSMA has extended an invitation to auxiliary

---

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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members for this important meeting. Washington columnist and author Robert D. Novak will speak.

The big social event of the week wouldn't be complete without as many couples as possible. The "Far East Fling" is scheduled for 7:00 o'clock in the headquarters hotel on Wednesday evening.

"It Could Happen to You"

Plan to attend the breakfast workshop at 7:30 a.m. Thursday with the remarkable Jeanne Bray of the Columbus Police Department. Mrs. Bray is particularly concerned with personal safety and will talk on the subject "It Could Happen to You." She joined the Columbus Police Department in November, 1960. As part of her 16 weeks of training in the Police Academy, she received instruction in the use of firearms. Later as a member of the Columbus Police Pistol Team, she captured the title of National Policewoman's Combat Pistol Champion in five successive years.

In 1964 Policewoman Bray was honored by being selected as the Columbus Citizen-Journal's Outstanding Sportswoman of the Year. She is currently assigned to the Public Affairs Bureau of the Police Department.

Thursday Morning Session

Following the breakfast, delegates, alternates and members will assemble for the second business session. Dr. Richard L. Fulton, OSMA President-Elect, will speak. Mrs. Robertson, our national president-elect, will install the new state officers. At the conclusion of the session, there will be a reception for Mrs. Carl F. Goll and the other incoming officers.

"Out of This World"

Honored guests at Thursday's luncheon will be Mrs. Robertson, and our OSMA advisors: Dr. Oscar W. Clarke, Dr. Paul N. Ivins, and Dr. Maurice F. Lieber. Dr. Clarke, chairman of the advisors, will speak briefly about the relationship of our two organizations. The luncheon chairman, Mrs. Roscoe Kennedy, has asked us not to reveal too much about the decor for the luncheon, other than to say it will really be "out of this world."

Our guest speaker will be Mrs. Woody Hayes, with the provocative topic "If you are alive, you are involved." Mrs. Hayes is described as a dynamic speaker and personality and has earned quite a fine reputation for herself, other than being the wife of Ohio State's famous football coach. Recently she addressed the Sports Writers Club of America in Chicago and, reportedly, "just

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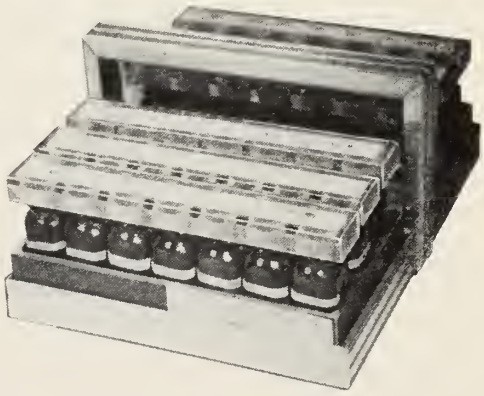
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about wowed the men." In addition to Mrs. Hayes' talk, there will be musical entertainment. Gals, go to the OMPAC luncheon with your husbands on Wednesday and then take them to the Auxiliary luncheon on Thursday. Turn about is fair play, you know!

This event officially ends the auxiliary convention, but the OSMA program that afternoon should be well worth hearing. Dr. Norman Vincent Peale will speak at the OSMA General Session at 2:00 p.m. in the Veterans Memorial Building.

Convention Chairmen

It takes a lot of woman-power to stage a convention and this year the top job is being handled by auxilians from two different counties: Mrs. Reuben Gould, Cuyahoga, chairman, and Mrs. John Riepenhoff, Franklin County, co-chairman. This is something of a departure in convention tradition, but OSMA's switch from Cleveland to Columbus for 1970 necessitated a change in the way our convention is usually handled. We could not impose on the Franklin County Auxiliary again to take on the full and heavy responsibility for plans.

Mrs. Gould and Mrs. Riepenhoff, therefore, will be assisted by committee chairmen from all over the state. They include: Registration, Mrs. Joseph Kaplan; Credentials, Mrs. Elden C. Weckesser; Tickets and Finance, Mrs. Daniel S. Wolff; Roll Call, Mrs. Saul Krasne; Pages, Mrs. William Mast; Sponsors, Mrs. Christopher Colombi;

Thursday Luncheon, Mrs. Roscoe Kennedy; Board Luncheon, Mrs. H. I. Humphrey; Workshop Breakfast, Mrs. Albert May; Program, Mrs. J. Paul Sauvageot; Election and Tellers, Mrs. Harry Nenni;

Hospitality, Mrs. Louis Chaboudy; VIP's, Mrs. Karl Ritter; Birthday Tea, Mrs. Carl E. Tetirick; Publicity, Mrs. C. W. Russell; and Resolutions, Mrs. S. J. Glueck.

Last Minute Reminders

Our president, Mrs. Samuel L. Meltzer, urges all auxilians to secure their room reservations at the Christopher Inn as early as possible. The *Auxiliary News* will carry a special reservation blank for members to fill out and send in for the Tea, Breakfast-Workshop, and Luncheon.

County auxiliaries are asked to bring their scrapbooks or any other material they might like to have displayed during the convention. There will be a special room set aside for this display. Yearbooks will also be shown but these have already been submitted to the Central Office.

Members-at-large are especially invited to attend the state meeting. Mrs. Carl M. Frye, MAL chairman, will welcome each and every one.

In Memorium

Auxilians are saddened by the news of two recent deaths, Mrs. Farrell T. Gallagher, of Rocky River, and Mrs. Frank Gastineau, of Indiana. Mrs. Gallagher was one of our former state presidents, serving in 1951-52. Mrs. Gastineau was the only woman member of the AMPAC Board and served as its secretary-treasurer.

County Societies' Officers and Meeting Dates

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High St.

ADAMS—Gary J. Greenlee, President, Farmers' Bank Building, Manchester 45144; Hazel Sproull, Secretary, P.O. Box 337, West Union 45693, 3rd Thursday, April, July, Oct. and Jan.

BROWN—Philip Pfalzgraf, President, Ohio Pike, Amelia 45102; Robert Benintendi, Secretary, 117 Cherry St., Georgetown 45121. 3rd Sunday (variable).

BUTLER—John H. Varney, President, 3207 Sheldon Rd., Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, 110 North Third St., Hamilton 45011. 4th Wednesday.

CLERMONT—Kurt Platschik, President, 4450 Mt. Carmel-Tobasco Road, Cincinnati 45244; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103; 3rd Wednesday except July, August and December.

CLINTON—Arthur F. Lippert, President, 110 East Locust St., Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday.

HAMILTON—Robert S. Heidt, President, 2340 Auburn Ave., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday, except June, July, Aug. and Dec.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson St., Greenfield 45123.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason 45040; Orville L. Layman, Secretary, 22 West Fourth St., Franklin 45005. 2nd Tuesday.

Second District

Councilor: George J. Schroer, Ft. Loramie 45845
20 S. Main St.

CHAMPAIGN—Lewis Inskeep, President, 848 Scioto St., Urbana 43078; Terrence F. Grogan, Secretary, 848 Scioto St., Urbana 43708. 2nd Wednesday.

CLARK—Wesley E. Knaup, President, 1054 East High St., Springfield 45505; Mrs. Marion Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone St., Springfield 45503. 3rd Monday, except June, July, Aug. and Dec.

DARKE—E. W. Browne, President, 330½ West Fourth Street, Greenville 45331; Giles Wolverton, Secretary, Health Department, Court House, Greenville 45331. 3rd Tuesday.

GREENE—Rudi Sotlar, President, 12 South Limestone Street, Jamestown 45335; Mrs. W. F. Whitt, Executive Secretary, 966 Whitestone St., Xenia 45385. Last Friday of every month.

MIAMI COUNTY—Kenneth Faze, President, 3 Duerr Drive, West Milton 45383; Martha L. Derr, Executive Secretary, P.O. Box 467, Piqua 45356. 1st Tuesday.

MONTGOMERY—Robert A. Bruce, President, 1126 South Main St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. Monthly meeting dates as established.

PREBLE—J. D. Darrow, President, 228 North Barron St., Eaton 45320; J. R. Williams, Secretary, 228 North Barron St., Eaton 45320. No regular meeting date.

SHELBY—George J. Schroer, President, 20 South Main St., Fort Loramie 45845; William F. Menteges, Secretary, 870 South Main Ave., Sidney 45365. 2nd Tuesday of March, June, September and December.

Third District

Councilor: Dwight L. Becker, Lima 45802
Box 1272

ALLEN—Alexander C. Reed, President, 819 West North St., Lima 45801; William E. Noble, Secretary, c/o Memorial Hospital, Linden & Mobel Ave., Lima 45804. 3rd Tuesday.

AUGLAIZE—John F. Bowling, President, N. Knoxville Rd., St. Marys 45885; Barbara Cummins, Secretary, 310 Perry St., Wapakoneta 45895. 1st Thursday every other month, starting with January.

CRAWFORD—Horace B. Newhard, President, 140 Hill St., Bucyrus 44820; C. Fabrigar, Secretary, 139 Gaius St., Bucyrus 44820. Meeting date variable.

HANCOCK—Robert Brown, President, 868 South Main St., Findlay 45840; Truman S. Smith, Secretary, 145 West Wallace St., Findlay 45840. 1st Tuesday monthly.

HARDIN—Jay Pfeiffer, President, 215 Main St., Kenton 43329; John Hughes, Secretary, 601 Pattison Ave., Kenton 43326. 2nd Tuesday evening monthly.

LOGAN—Donald Wyse, President, Oakhill Medical Association, West Liberty 43357; Douglas W. Beach, Secretary, 1008 North Main St., Bellefontaine 43311. 1st Friday monthly.

MARION—John E. Aiken, President, 1040 Delaware Ave., Marion 43302; Brooks Sitterly, Secretary, McKinley Parkway Dr., Marion 43302. 1st Tuesday monthly.

MERCER—George H. McIlroy, President, 123 East Fayette St., Celina 45822; D. J. Schwieterman, Secretary, Rolfes Rd., Maria Stein 45860. 3rd Thursday.

SENECA—Leroy Cummings, President, 60 Sycamore St., Tiffin 44883; Donald Shanabrook, Secretary, 455 West Market St., Tiffin 44883. 3rd Tuesday evening Jan., March, May, July, Sept. and Nov.

VAN WERT—Thomas R. Wilson, President, Van Wert County Hospital, Van Wert 45891; Robert Scheidt, Secretary, Medical Arts Building, Van Wert 45891. 4th Friday.

WYANDOT—D. P. Smith, President, Pennington St., Sycamore 44882; K. K. Solacoff, Secretary, 777 North Sandusky Avenue, Upper Sandusky. 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43624
316 Michigan St.

DEFIANCE—Jack A. Kane, President, Central Foundry, Defiance 43512; Miss Lois Coffin, Executive Secretary, P.O. Box 386, Defiance 43512. 1st Saturday.

FULTON—R. L. Davis, President, 137 South Fulton St., Wauseon 43567; M. S. Renfrew, Secretary, Lutz Rd., Archbold 43502. Quarterly meetings March, June, Sept. and Dec.

County Society Roster (continued)

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545; B. L. Sickmiller, Secretary, 1400 E. Second St., Defiance 43512.

LUCAS—Roland L. Kennedy, President, 4639 Farmington Rd., Toledo 43623; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday,

OTTAWA—Donald F. Loeffler, President, 521 East Second St., Port Clinton 43452; Gordon R. Ley, Secretary, P. O. Box J, Port Clinton 43452. 2nd Thursday evening monthly.

PAULDING—Kirkwood A. Pritchard, President, 119 South Main St., Paulding 45879; Don K. Snyder, Route #2, Paulding 45879. 3rd Monday monthly at the Paulding County Memorial Hospital.

PUTNAM—Arthur P. Daniel, Secretary, 144 North Walnut St., Ottawa 45875. 1st Tuesday.

SANDUSKY—Allen Schaengold, President, 325 South Park Ave., Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday.

WILLIAMS—V. L. Boerger, President, Edgerton 43517; L. Rivera, Secretary, 307 First St., Pioneer 43554. 3rd Tuesday.

WOOD—William Roberts, President, North Baltimore 45872; William F. Lord, Secretary, 950 West Wooster St., Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robechek, Cleveland 44122
3461 Warrensville Center Rd.

ASHTABULA—W. B. Millberg, President, 430 West 25th Street, Ashtabula 44004; Miss Dorothy L. Geho, Executive Secretary, P.O. Box 205, Geneva 44041. 2nd Tuesday.

CUYAHOGA—Leo Walzer, President, 11811 Shaker Blvd., Cleveland 44120; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106. Board meets 2nd Tuesday.

GEAUGA—Oscar Brinckmann, President, 12475 Hospital Dr., Chardon 44024; Mrs. Ruth Milgate, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024. 2nd Friday.

LAKE—John J. Cahill, President, 36001 Euclid Ave., Willoughby 44060; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44094. 4th Wednesday of Jan., March, May, Sept. and Nov.

Sixth District

Councilor: Maurice F. Lieber, Canton 44703
515 Third St., N. W.

COLUMBIANA—John A. Fraser, President, 403 Little Building, East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460. 3rd Tuesday monthly.

MAHONING—Robert L. Jenkins, President, 21 Wickliffe Circle, Youngstown Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44505. 3rd Tuesday, except June, July and August.

PORTAGE—Kenneth F. Rupp, President, 9160 State Route 43, Streetsboro 44240; Miss Maria Motyka, Executive Secretary, 430 Grant St., Akron 44311. 3rd. Tuesday.

STARK—Frank O. Goodnough, President, Peoples-Merchants Trust Building, Massillon 44646; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday.

SUMMIT—Edwin W. Cauffield, President, 505 Ohio Building, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 2nd Tuesday, excluding July and August.

TRUMBULL—J. R. Phillips, President, St. Joseph's Hospital, N. Tod Avenue, Warren 44485; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday, September through May.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth St.

BELMONT—Thomas L. Ring, President, 3205 Belmont Street, Bellaire 43906; Bertha M. Joseph, Secretary 100 South 4th Street, Martins Ferry 43935. 3rd Thursdays, except January, May, July and August.

CARROLL—T. J. Atchison, President, 292 East Main St., Carrollton 44615; Jack L. Maffett, Secretary, 264 South Lisbon St., Carrollton 44615. 3rd Tuesday.

COSHOCTON—Myron Saturski, President, 149 South Bridge Street, Newcomerstown 43832; Robert W. Secrest, Secretary, 1926 Melbourne Road, Coshocton 43812. 2nd Tuesday.

HARRISON—R. W. Weiser, President, Jewett 43986; Janis Trupovnieks, Secretary, Hopedale 43976. Quarterly, March, June, Sept. and Dec.

JEFFERSON—Crist G. Strovilas, President, 812 North Fourth St., Toronto 43964; Mrs. Mary Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952. 4th Tuesday, except Aug. and Dec.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—P. T. Doughten, President, 551 Wabash Ave., New Philadelphia 44663; M. R. Puterbaugh, Secretary, 104 Iron Ave., Dover 44622.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson

ATHENS—Dale Mattmiller, President, Hudson Health Center, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. Second Tuesday except July and August.

FAIRFIELD—R. A. Welsh, President, Lancaster-Fairfield Hospital, Lancaster 43130; C. R. Reed, Secretary, 309 East Main Street, Lancaster 43130. 2nd Tuesday.

GUERNSEY—Merritt C. McCuskey, President, 1200 Edgeworth Ave., Cambridge 43725; Quentin F. Knauer, Secretary, 100 Clark Ct., Cambridge 43725. 1st Tuesday monthly, 7 P.M., Cambridge Country Club.

LICKING—Edward A. Carlin, President, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055; G. Franklin Gabe, Secretary, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055. 4th Tuesday monthly.

MORGAN—Asa Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 East Union Ave., McConnelsville 43756.

MUSKINGUM—James F. Morton, President, 727 Market St., Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Ave., Zanesville 43701. 1st Tuesday.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Box 239, Caldwell 43724. 1st Tuesday.

County Society Roster (continued)

PERRY—A. G. Cruz, President, 203 North Main St., New Lexington 43764; R. E. Herendeen, Jr., 203 North Main St., New Lexington 43764.

WASHINGTON—Gregory B. Krivchenia, President, 326 Third St., Marietta 45750; Donald E. Fleming, Secretary, Vincent 45784. 2nd Wednesday monthly.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—Arturo de Lamerens, President, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631; Donald M. Thaler, Secretary, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631. Quarterly meetings at call of officers.

HOCKING—Lethia W. Starr, President, 109 Mulberry St., Logan 43138; J. W. Doering, Secretary, 42 North Spring St., Logan 43138. 2nd Tuesday monthly.

JACKSON—Earl Levine, President, 120 North Ohio Avenue, Wellston 45692; John M. Cook, Secretary, Box 316, Oak Hill 45656. Meetings when called.

LAWRENCE—A. Burton Payne, President, 411 Center Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly meetings.

MEIGS—Charles J. Mullen, President, 210½ East Main St., Pomeroy 45769; E. Butrimas, Secretary, 204 East Main St., Pomeroy 45769.

PIKE—W. W. Wiltberger, President, 330 East North St., Waverly 45690; Thomas Hwang, Secretary, 300 Cherry St., Waverly 45690. 1st Tuesday monthly.

SCIOTO—Joseph T. Gohmann, President, Mercy Hospital, 1248 Kinneys Lane, Portsmouth 45662; Mr. Lowell Thompson, Executive Secretary, 1805 27th St., Portsmouth 45662. 6:30 2nd Tuesday.

VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050
104 E. Gambier St.

DELAWARE—John L. Binkhorst, President, 26 Northwood Dr., Delaware 43015; Lloyd E. Moore, Secretary, Magnetic Springs 43036. 3rd Tuesday except June, July and Aug.

FAYETTE—H. W. Payton, President, 36 South Main Street, Jeffersonville 43163; M. H. Roszmann, Secretary, 1005 East Temple Street, Washington C. H. 43160. 2nd Friday.

FRANKLIN—Philip H. Taylor, President, 3545 Olentangy River Rd., Columbus 43214; Mr. W. "Bill" Webb, Executive Secretary, 17 South High St., Suite 528, Columbus 43215. 3rd Tuesday except June, July and Aug.

KNOX—James C. McCann, President, Medical Arts Building, Mount Vernon 43050; Robert Westerheide, Secretary, Medical Arts Building, Mount Vernon 43050. 1st Wednesday.

MADISON—Brawley Arikawa, President, 176 North Madison Road, London 43140; William T. Bacon, Secretary, 194 Elm Street, London 43140. Four times a year, 2nd Wednesday (3, 6, 9, 12).

MORROW—David James Hickson, President, 712 Baker St., Mount Gilead 43338; Lowell Murphy, Secretary, 209 South Main St., Cardington 43315. 1st Tuesday monthly.

PICKAWAY—H. H. Swope, President, 400 North Court St., Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney St., Circleville 43113. 1st Tuesday except July and Aug.

ROSS—Roy Manning, President, 1 Overlook Dr., Chillicothe 45601; Paul MacCarter, Secretary, 60 Central Center, Chillicothe 45601. 1st Thursday.

UNION—John R. Linscott, President, 225 Stocksdale Dr., Marysville 43040; May B. Zaugg, Secretary, Route 5, Timber Trails, Marysville 43040. 1st Tuesday of Feb., April, Oct. and Nov.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Rd.

ASHLAND—William Emery, President, 247 Sandusky Street, Ashland 44805; J. H. Cooperrider, Secretary, 637 North Union Street, Loudonville 44842. 1st Thursday.

ERIE—R. H. Williamson, President, 410 Wasta Rd., Huron 44839; Mrs. Barbara Wolfert, Executive Secretary, 1428 Hollyrood Rd., Sandusky 44870. 2nd Tuesday except July and Aug.

HOLMES—Daniel J. Miller, President, Walnut Creek 44687; Charles H. Hart, Secretary, 109 South Clay St., Millersburg 44654. First (or Second) Thursday 7 P.M. (Sometimes it may follow hospital staff meeting.)

HURON—John E. Rosso, President, 218 Myrtle Ave., Willard 44890; Russell R. Fisher, Secretary. 257 Benedict Ave., Norwalk 44857. 2nd Wednesday of February, April, June, October and December.

LORAIN—Robert P. McFarland, President, Oberlin Clinic, Inc., 224 West Lorain Street, Oberlin 44074; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday for REGULAR MEETINGS. Last Thursday of the month for COUNCIL MEETINGS.

MEDINA—H. E. Grover, President, 146 North Lyman Street, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina 44256. 3rd Thursday.

RICHLAND—Robert W. Jones, President, 120 Sturges Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, c/o Mansfield General Hospital, Mansfield 44903. 3rd Thursday except June, July and August.

WAYNE—Frank Cebul, President, 1740 Cleveland Road, Wooster 44691; Thomas Graves, Secretary, 1740 Cleveland Road, Wooster 44691. 2nd Wednesday of alternate months.

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(Continued on Next Page)

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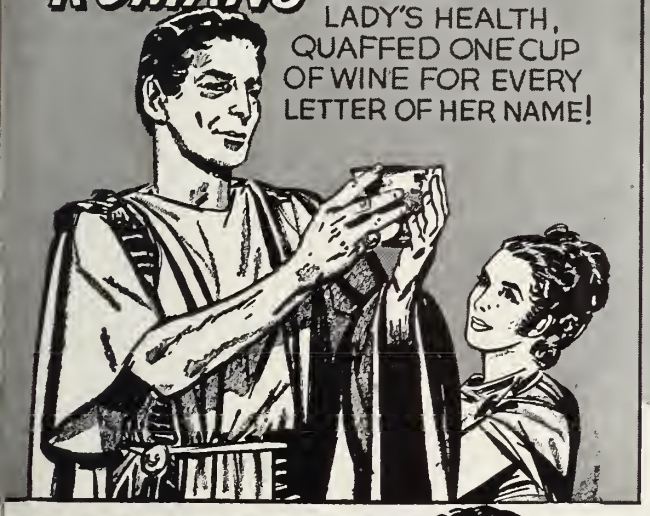
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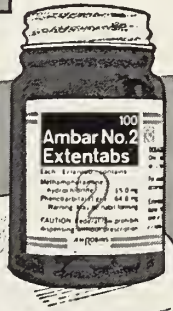


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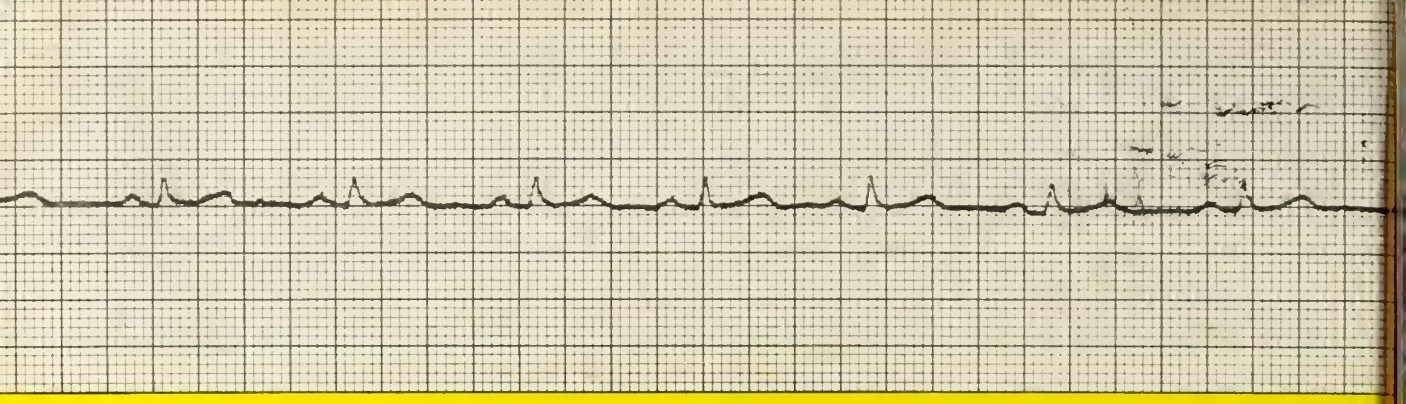
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Vol. 66 • No. 5

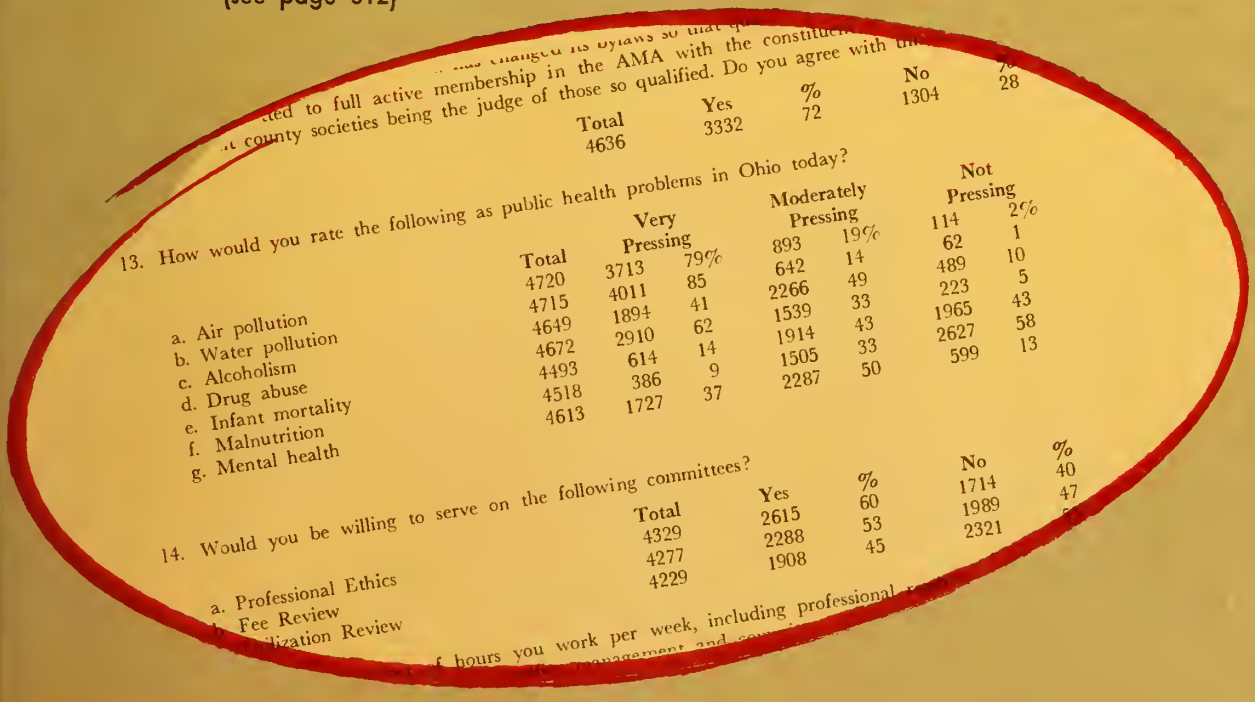
The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

THE FRANCIS A. COUNTWAY
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OSMA members respond to opinion survey

(see page 512)



...ted to full active membership in the AMA with the constitue...
...t county societies being the judge of those so qualified. Do you agree with th...

	Total	Yes	%	No	%
	4636	3332	72	1304	28

13. How would you rate the following as public health problems in Ohio today?

	Total	Very Pressing		Moderately Pressing		Not Pressing	
a. Air pollution	4720	3713	79%	893	19%	114	2%
b. Water pollution	4715	4011	85	642	14	62	1
c. Alcoholism	4649	1894	41	2266	49	489	10
d. Drug abuse	4672	2910	62	1539	33	223	5
e. Infant mortality	4493	614	14	1914	43	1965	43
f. Malnutrition	4518	386	9	1505	33	2627	58
g. Mental health	4613	1727	37	2287	50	599	13

14. Would you be willing to serve on the following committees?

	Total	Yes	%	No	%
a. Professional Ethics	4329	2615	60	1714	40
b. Fee Review	4277	2288	53	1989	47
...lization Review	4229	1908	45	2321	

...f hours you work per week, including professional ...

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Proceedings of The Council ..... Page 505
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VOL. 66 MAY, 1970 NO. 5

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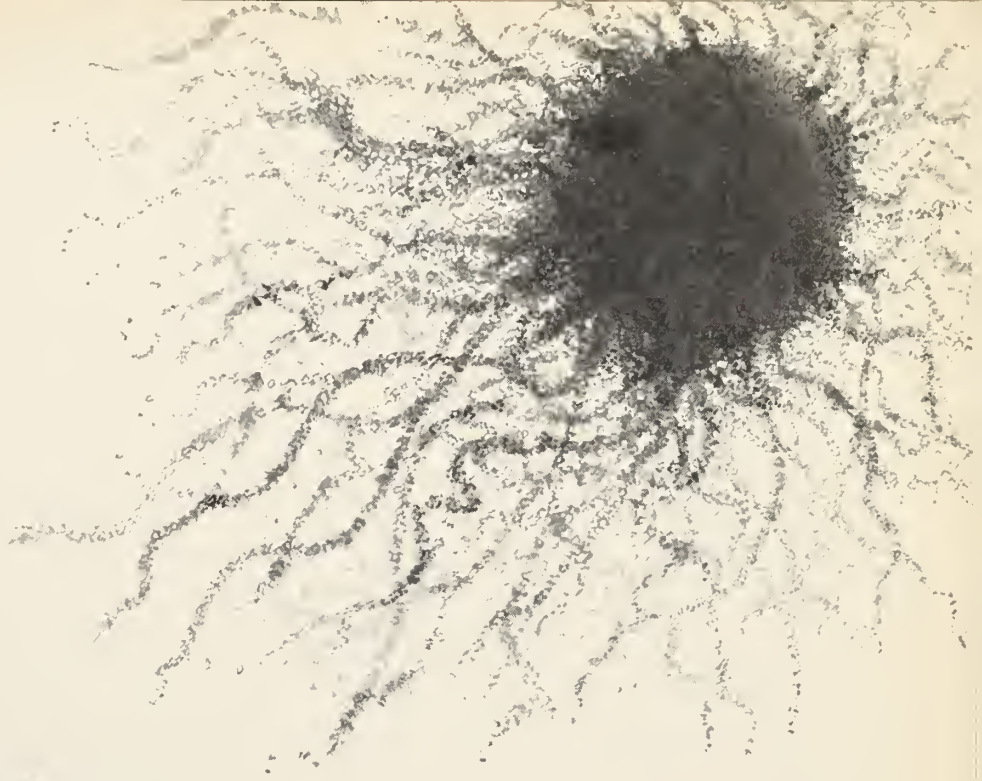
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then antibiotic therapy last week.

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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The Rising Cost of Health Care

By Bernard J. Lachner, M.B.A.

I AM PLEASED to have this opportunity to present briefly "The Rising Cost of Health Care." My remarks, though general, will be related primarily to hospitals costs, rather than to physician or dentist fees, the cost of pharmaceuticals, or other general areas of health expenditures.

Total expenditures for Health Care (Graph 1) reached the $60.1 billion mark in 1969, approximately 7 percent of the Gross National Product of $933 billion in this country. This has increased from $11 billion in 1950, which was 4.5 percent of the Gross National Product. As you will note, there are several factors that have contributed to this growth. (Graph 2) They include the factor of national population growth which amounted to 18 percent of this increase.

Next the consumer price index cost of living increase of approximately 48 percent during this period, and finally 34 percent resulted from greater utilization of services and the use of new medical techniques.

Where this money comes from is important. (Graph 3) Private spending this past year accounted for about 60 percent with government picking up 40 percent. This is significant when we note the direction we are taking since just four years ago, private spending amounted to 75 percent and government paid 25 percent of the total. The impact of massive health legislation during the Johnson Administration, (Graph 4) including service programs such as Medicare, Medicaid, Regional Medical Programs and Comprehensive Health Planning, as well as educational and construction monies in the Health Manpower area clearly delineate a path for the future. There are many voluntary hospitals in this country that are receiving up to 50 percent or more of their operating income from government, whether it is a county welfare department, state welfare medicaid program, or the Federal Medicare undertaking.

The rising cost of Health Care is not only related to salaries of employees, supplies, and equipment usage in hospitals, it is related to new facilities, to health education, to research, to increased utilization of the services, and to any increase in the percentage of the populace that use these services.

Please remember this as we review some of these aspects.

Unique Status of Hospital

The Hospital of 1970 resembles in many ways the Church of the Middle Ages in Europe. It is difficult to exaggerate the importance of the hospital in modern American Society. It is the central institution in the organization and delivery of health care to each individual patient. It is also central to the education of each and every health care professional, as well as the day to day practice of medicine and the application of all medical research findings. For all intents and purposes the entire third party insurance concept that we have known since the early 1930's has been directed to and related to care in the acute general hospital.

Think about your own insurance program. My guess is you have to be in a hospital, be sick, and have something done for you, on you, and to you to receive the benefits of your prepayment programs. Diagnostic care is usually not covered, limited maternity benefits, meager pediatric relief, limited out patient and emergency room coverage, and practically no benefits for visits to your physician's office. In other words, we have concentrated our primary effort and our major financial resources in the Health Care field in and around the voluntary hospital and the acute care episode of illness. Nothing on preventive care, to keep you out of the hospital and nothing to take care of you after you get out of the hospital, home care, nursing home care—extended care facilities. Nothing that is, until the last half of the 60's with the advent

GRAPH 1

Gross National Product Comparisons — U.S.A.

	Health Care Expenditures (Billions of Dollars)	% GNP
1950	11	4.5
1969	60	7.0

Mr. Lachner is Assistant Dean, Ohio State University College of Medicine, and Administrator, the Ohio State University Hospitals. This article is based on an address given before the Rotary Club of Columbus on January 19, 1970.

of government programs and limited third party insurance riders in many of these neglected fields.

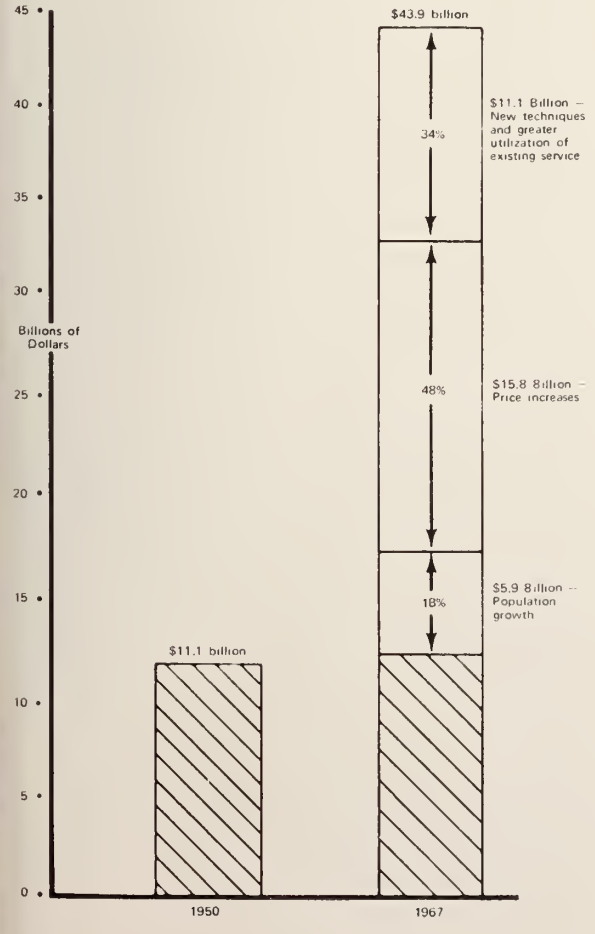
Why, you say, has there been such a lack of vision, an absence of planning, little or no **apparent** control of costs, shortage of manpower, impersonal employees, **alleged** poor management, impossible emergency room service and perhaps one or two other angry situations or inconveniences that you, your family, or an acquaintance has experienced.

Worldwide Dilemma

First of all, let me assure you that the dilemma facing America, in this regard, is not peculiar to us. Health Care systems the world over are facing these problems—inadequate financing, shortage of manpower, not enough of the right facilities in the right place, providing the right services. Let's look at the Health Care systems of Great Britain and Sweden. Great Britain has a National Health Service operated by the Central Government. (Graph 5) In 1948, over 90 percent

GRAPH 2

FACTORS AFFECTING THE INCREASE IN PERSONAL HEALTH CARE EXPENDITURES 1950 AND 1967



GRAPH 3

Private Sector and Governmental Health Care Spending

	Governmental (% of Total)	Private (% of Total)
1965	25	75
1969	40	60

of Great Britain's hospitals were nationalized into a single structure. Tax revenues are allocated by the Central government and account for 80 percent of the funds used. Employer and employee payroll deductions provide the remaining funds.

In Sweden, hospital care is free at time of service and out patients pay 25 percent of the physician's fee. (Graph 6) The government pays the remainder of this bill. County Councils own, and operate the full range of service. National tax revenues, however, supply about one third of the funds required, and County and City taxing bodies are responsible for providing the remaining amount. There is no employer-employee payroll contribution. Let's look briefly at the Gross National Product (GNP) (Graph 7) of several countries in meeting their Health Care needs. Here you will note, with the exception of Norway, that these countries have expenditures similar to that of the United States.

The point that does need to be emphasized is that rising Health Care costs, manpower short-

GRAPH 4

Recent Public Program Development

Medicare
Medicaid
Regional Medical Programs
Comprehensive Health Planning
Health Manpower
Health Service Facilities

ages, inadequate financing, are not unique to the United States. The trend around the world has been found to be independent of type of hospital ownership, independent of the extent of operational control exercised by a central authority, independent of the source or control of funds and independent of the patterns of manpower staffing. The pressures of increasing population, increased staff-patient ratios, shorter periods of hospitalization, greater admission rates, and the exciting na-

ture of the medical science revolution are identical in these societies, and are common causative factors.

Point of Reference

When we talk of costs being too high, one of the items usually lacking in such pronouncements is a basis of comparison. If costs are "too high" they must be compared to the cost of some other type of service, or to the same service at some previous time. The hospital service of today is not the hospital service of yesterday. None of us want it to be. The hospital of today is no longer supported by charity. The idea that free care should be provided by hospital employees motivated by charitable impulses is no longer valid. The idea that hospitals can be run by retired physicians, ministers, or someone's nephew, or by anyone else not possessing management skills, is as foreign to most hospitals today as it is to any multi-million dollar institution or industry.

A comparison of hospitals with hotels or any other segment of our economy is senseless. Caring for the sick and injured is in no way similar to manufacturing and retailing commodities. We have never had any person present themselves at our doors, at any hour, on any day, and ask for anything less than the very best we had to offer. No January sales, no discount services, no specials, no seconds—they aren't interested in coming back tomorrow or next week. The very best we have, at any hour, any day, whether it is an upset stomach, a toe cut in a lawn mower, an auto accident, a prison riot, the birth of a baby, elective surgery, diagnostic care, or a terminal cancer.

This attitude is shared by all of us when it comes to our own health.

The issue of inefficient management is raised in some uninformed quarters with some regularity, and usually relates to impersonal service, waiting for service, inefficient employee performance and an institution that loses money. I'm occasionally impressed that hospitals don't have a corner on that market! But it does point up the fact that we do expect more from our hospitals than perhaps, from other businesses.

Obligation in the Community

There is no question you can make money in the hospital business. You can cut down on staffing, close out the "losing" services, such as the emergency room, pediatrics, obstetrics, nursery, intensive care, renal dialysis units, as well as many laboratory and x-ray tests and procedures. All educational programs and research activities could be shunted aside also. This, of course, is obvious to you, and it is not the issue, but it strikes

GRAPH 5

Great Britain
(A National Financing System)

National Government Contribution to Health Care	80%
Employee/Employer Contribution	20%
	100%

right at the point of what a hospital is, its place in the community as a social institution with responsibilities extending beyond the profit and loss statement.

We are very definitely in a period of rising hospital costs. This will continue for the foreseeable future in the 8 to 15 percent range annually. Not only will hospitals meet the cost of living increase, but they will be faced with "catch up" for those employees' wages and fringe benefits that are below our national standards for similar work. (Graph 8)

Graph 8 shows that in spite of significant salary increases in the last five years, hospital employees have done little more than keep pace. Those people in the construction trades, schools and education, and manufacturing areas maintained their respective salary advantages as workers and career identification.

Now, where does all of this bring us? As we look to the future the role of the hospital will become more central to the community and its planning for Health Care. With its life and death impact on each individual in the community, its sizable financial contribution to the local economy, its relationship to land use and urban planning, it will continue, along with schools and education, with financing patterns for local government service and minority relations—to occupy a major role in the emerging public policy.

No Ideal Model

Is there such a thing as a hospital or health care system model to which we can aspire? Is there enough money anywhere in the world to buy all of the Health Care we desire? How are we going to finally get our hands on the controls

GRAPH 6

Sweden
(A Decentralized County Financing System)

National Government Contributions to Health Care	33%
City-County Contributions	67%
Employer-Employee	0%

of these problems of inadequate facilities and services—not enough financing, shortages of manpower, services for those people not now receiving adequate care?

We can begin to look at these problems by accepting the facts as they are. There is no model system we can hang our hats on!

The collective attitudes of our people have created a demand for service in excess of the health industry's current ability to respond promptly and efficiently.

Traditionally the hospital has been a passive reactor to demands put upon it by first of all, the medical profession and secondly, by the community. The idea that the hospital and its Board of Trustees, with its organized medical staff, should be a creative, initiating force, play a leadership role, is relatively new to each of these three parties. This holds promise perhaps, to the solution of many of our current impasses.

There are very few hospitals in this country that have any geographically defined areas of services that are manageable to any degree. There are many who feel concerned at the continued inroads into financing by government. In the area of government controls, a recent listing showed 68 different hospital facilities codes and service programs currently affected and regulated. I share the concern but not the promise that this holds. We know we are inadequately financed at present and the resources of the private area of our economy can never hope to pick this up again. Hence, government must do the task of financing an increased portion of these costs in conjunction with an expanded voluntary prepayment mechanism led by the Blue Cross and private insurance carriers.

Government's interest must be maintained in the area of financing and purchase of care, but not in the area of institutional operation.

Facing the Challenges

It is inevitable that the costs of Health Care will continue to spiral unless we clearly accept the many challenges confronting us. For example:

1. Comprehensive Health Planning in the best interest of the public must limit the appetite each hospital has for "their own" new facilities and services; the continued duplication of these facilities, such as, pediatric units, emergency rooms, cobalt and radioactive therapy, intern-resident programs, and many others must cease. Not every hospital needs to be a complete hospital. Why do we continue for instance, the economic waste in the area of psychiatric illness by continuing to build and operate mental health facilities in remote locations. Approximately 50 percent of the hospital beds in this country are for psychiatric patients. For the most part they are entirely outside the main stream of active treatment and rehabilitation services. I mean remote in any context except on the same campus with an acute general hospital where there is medical, nursing and paramedical expertise, where there will be active treatment programs.

2. There are many local issues such as in Columbus: As a community and as taxpayers, we must ask the question, why do most of the adult patients and practically all of the pediatric patients of welfare recipients go to University and Children's Hospitals respectively in this town? These are the two highest cost hospitals in the community, because of their comprehensive medical care, education and research programs. Are we getting our maximum welfare hospital dollar return in these programs when this happens?

3. The financing and evaluation of preventive medicine for all of us must be an immediate future goal. Both out patient and long-term care facilities are first-order business, although our recent history reads as though the acute general hospital and the physician's office are the only places to receive care after the fact. There must be extensive prepayment programs in each of these areas. It seems to me that very soon we will see a review and approval mechanism of hospital costs and charges by a group representative of the hospital's public. This will allow for an understanding of all concerned of the economics involved, the programs underway, as well as the services and facilities desired by the people. The hospital must become more involved with the other health agencies of the community and not remain as an isolated island of personally conceived excellence.

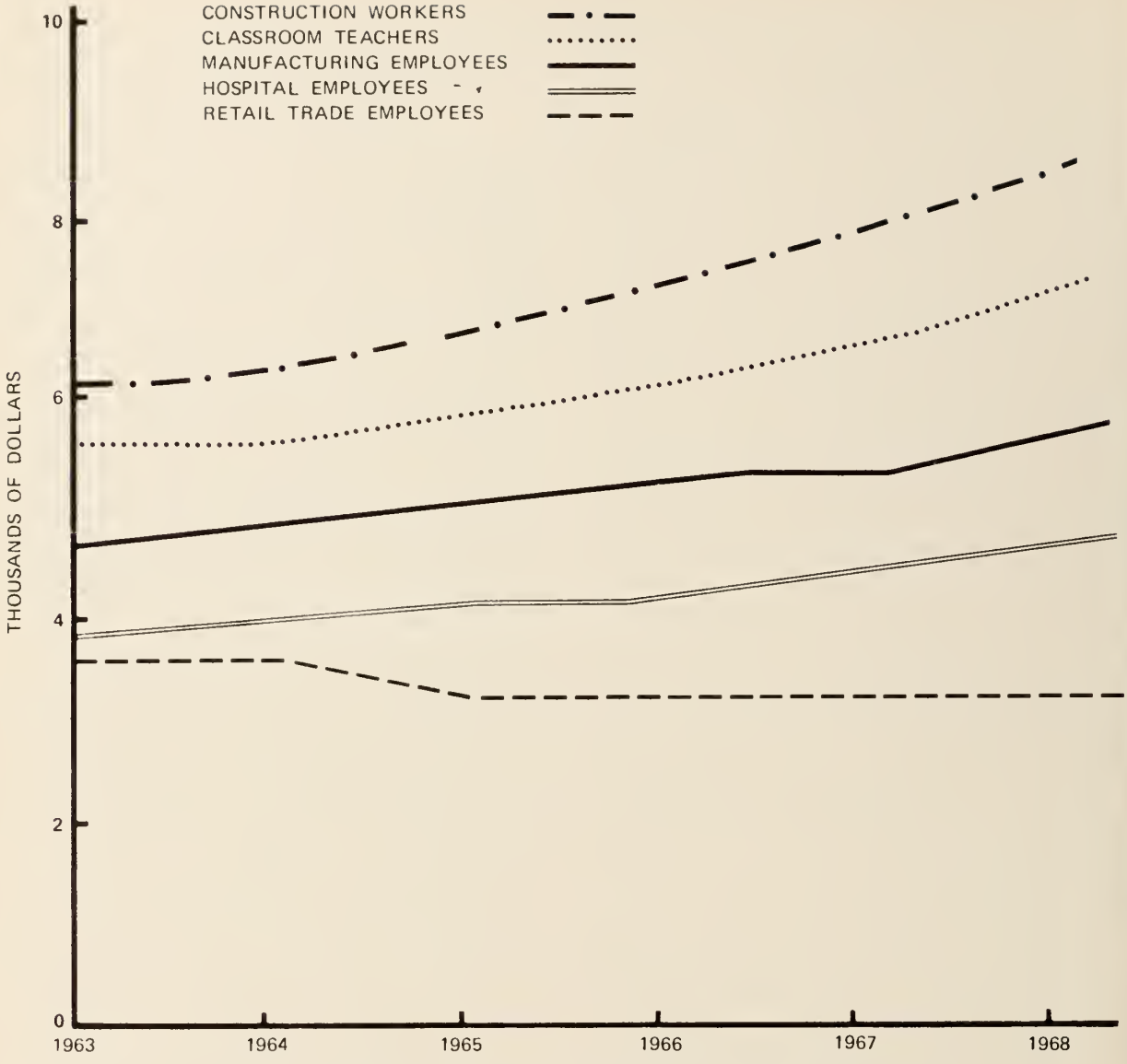
4. We cannot continue to admit patients to hospitals because they have inpatient insurance to cover the costs of care. The tough

GRAPH 7

Health Care Expenditures — 1968 (Selected Countries)

	Health Expenditures as a percent of GNP
Netherlands	5.9%
England and Wales	4.5%
Norway	2.4%
Denmark	5.5%
Sweden	7.0%
United States	6.4%

GRAPH 8



TRENDS IN AVERAGE ANNUAL SALARY FOR HOSPITAL EMPLOYEES AND OTHER SELECTED GROUPS, 1963 - 1968

decisions that the physician makes relative to whether or not he admits, often under pressure from his patient and his family, as well as perhaps, his hospital to keep the beds full, must be reviewed by his colleagues.

5. We must develop the measures of quality of care that are so necessary to effective progress in the future. A measure of quality in whose eyes?—the physician's? the patient's? the patient's family? the insurance carrier? others? What is the measure of a good physician? a good hospital? good patient care?

6. Finally we must continue to involve the physician and the community in the programming of our Health Care Programs. Any Health Care system design must have the active participation of the physician in such a manner as to retain his interest and enthusiasm and recognizing his role as the key individual in the diagnosis and treatment of the patient. There can be no Health Care system without the physician.

The Physician's Key Role

This key role holds the solution to many of our present dilemmas. There is nothing in our system to reward the physician for not doing something to a patient—for not prescribing a drug, for not ordering a laboratory or x-ray test, for not admitting to the hospital, for not performing surgery, for not scheduling a return visit. These are key issues. We cannot continue a peer judgment without measures of quality and quantity of care. This must be done by an enlightened medical

(Continued on Page 456)



ell, Dr. Cunningham! I was just telling Herbert hould talk to you about my allergy. ist my nose starts to tickle and..."

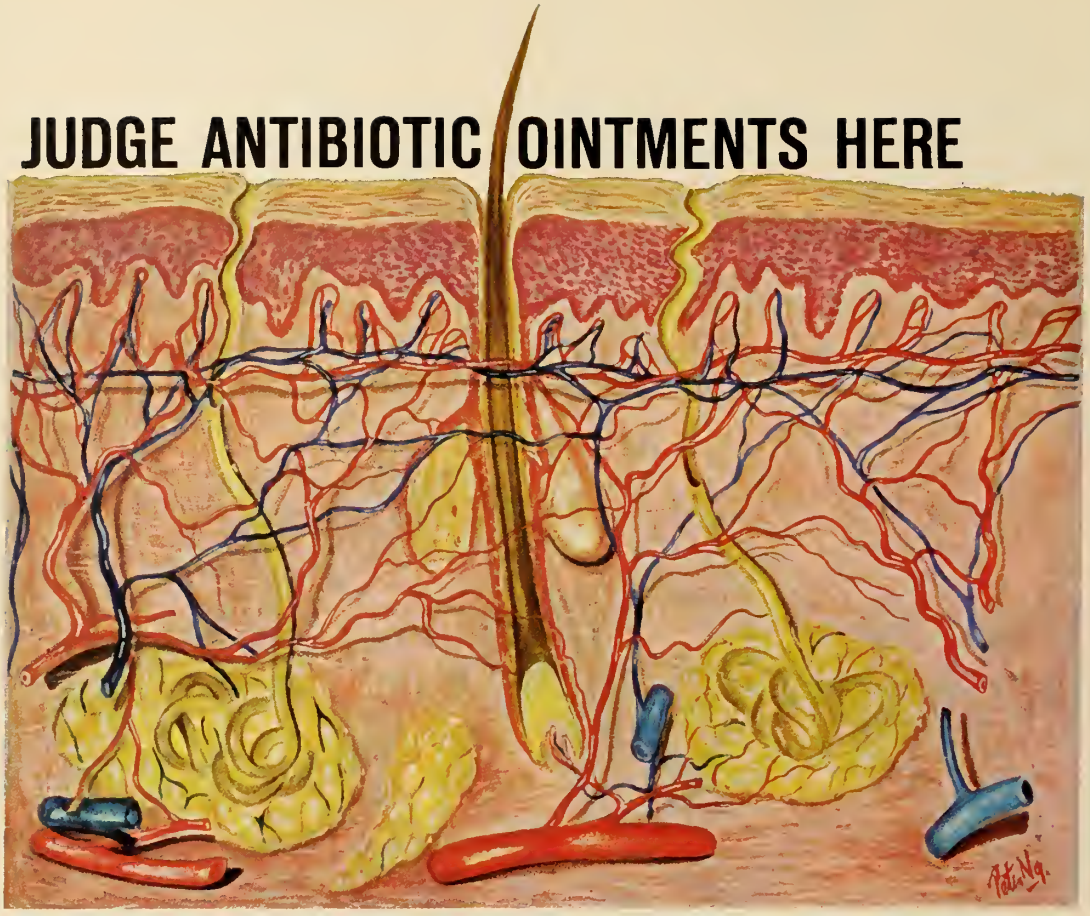
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*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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profession with data supplied to them upon which to make this very difficult evaluation. It must be peer judgment, but based upon substantive data. There are many other problem areas that bear on the costs of Health Care.

There are problems of increasing liability claims against the physician, the hospital and its staff, and resultant increases in cost because of this. In the absence of appropriate measures of the quality of care, patients' and plaintiffs' lawyers have been having a field day in the courts with suits against hospitals and physicians.

Another factor is the increased emphasis on full payment for services received from each person or agency responsible—not last year's per diem or an agency payment that runs six months to a year in arrears.

Another key issue is the area of manpower. We must continue the experiments with new health workers in new roles in increasing numbers. The educational process must change. It must constrict and be lengthened as need be, but not escape our quest for better utilization of scarce resources.

We cannot continue to use people in hospitals the way we have for 20-30 years. The nurse of today is very much different than that graduated 20 years ago. Yet most physicians, hospitals and patients cling to the old traditions of the role of the nurse that must be 25-30 years old.

There are some who believe we can zero in on many of these problems by a "public utility" approach. There are many reasons why this is not the panacea we are looking for, including the fact hospitals are not monopolys in the provision of all Health Care services.

The Proprietary Hospital is another area that is getting a good hard look at the present time.

Their message is simple—you can make money in the hospital business. Every hospital does not have to be a complete hospital. That is, not every hospital needs an emergency room, not every hospital needs to take maternity patients, not every hospital needs to be involved in the education of Health Care professionals. In other words, this is an example of planning for efficient, effective operation. A strong word of caution, however, this may or may not be an answer to a community's needs for comprehensive Health Care, and without measures of appropriate use raise serious questions as to their place in the system.

In New York State, for example, legislation has been passed recently banning proprietary ownership of hospitals, primarily because of the issue of conflict of interest.

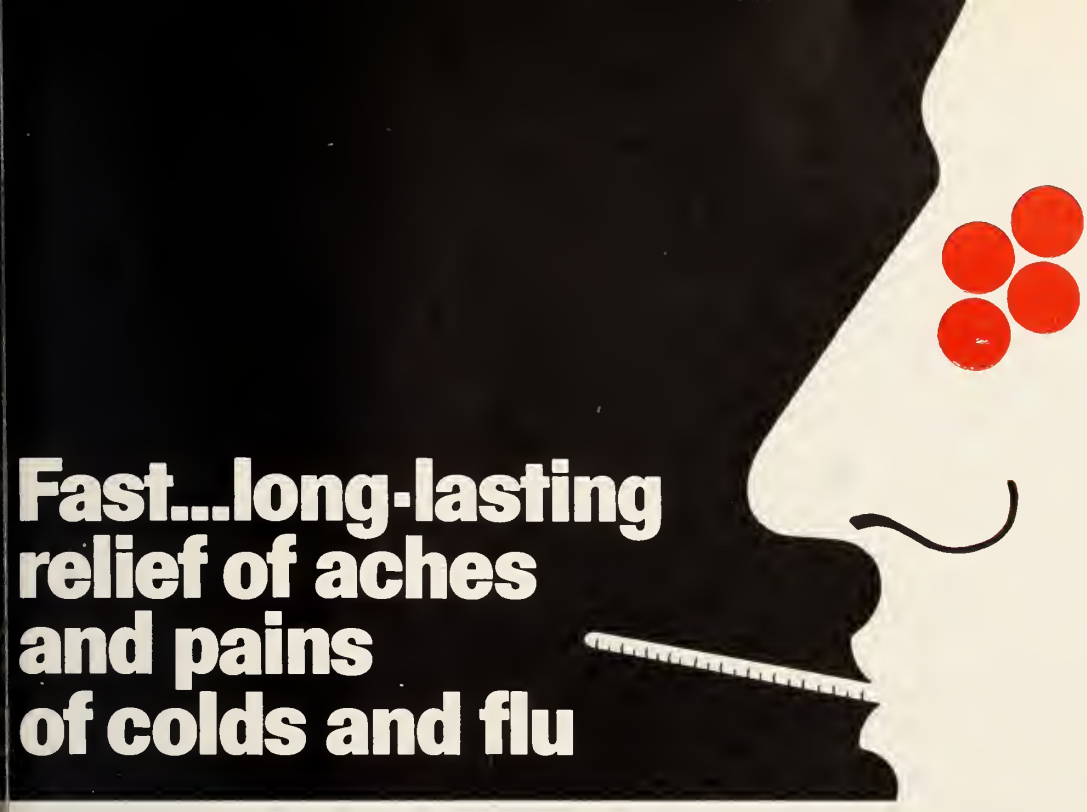
It does, however, point up the need for planning and control, not currently present in the system.

We've Come a Long Way

In closing, let me say, a great deal needs to be done to assist in the orderly expansion of our Health Care system. One key problem involves effective measures of patient care.

There is much talk now about the Health Care crisis—the media is full of it—a revolution all about us—and emphasis on new methods of delivery of Health Care as if these changes will be effective tomorrow or 1972 or 1975. Let me assure you this will not happen. Thoughtful people are very proud of where our Health Care system has brought us today, at the same time, recognizing we have staggering problems to cope with in the future. Medical Science and the social revolution have changed many of our practices within the short span of 20 years, and are causing considered judgments relative to our future goals and objectives. We are in the midst of an exciting time in the history of our Health Care system. It is not a time to run and shout fire, as if we have no solid base upon which to continue to build and react to change.

All of these considerations in one way or another, affect the costs of Health Care. We must move in the direction of keeping people well—rather than what we now have, which is taking care of those who are sick. We must all consider what it is we want in Health Care in the light of the practical economics of financially supporting it.



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The treatment of patients with Parkinson's Disease by stereotaxic surgery has been employed for the past 20 years with considerable success. However, it is now becoming apparent that many conditions other than Parkinson's Disease can be treated by these techniques. This study will attempt to clarify which conditions can be treated stereotaxically and to evolve criteria for selection of those patients.

The insertion of an electrode into the brain during treatment for these various conditions provides a unique opportunity for research in the pathophysiology of the condition being treated.

In addition to evaluating the effectiveness of various procedures, physiologic investigations will be conducted prior to, at the time of, and after surgery. This will involve recording of various reflex and physiologic mechanisms and electrical recording and stimulation of the brain at the time of surgery.

Primary among the conditions under study is intractable pain of organic etiology. This includes patients who have already undergone cordotomy either with no success or with a recurrence of their pain. Patients who are addicted to narcotics are particularly included. The relief of pain after lesions in various areas will be compared in hopes of determining which lesion is most satisfactory for which painful condition.

Many patients with involuntary movements caused by conditions other than Parkinson's disease will also be included. Patients with dystonia musculorum deformans, severe essential tremor, choreo-athetosis, or other conditions may be candidates for stereotaxic surgery. Certain selected patients with obsessive-compulsive behavior will be included in this study. Some patients with posture resembling spasmotic torticollis may also be treated by stereotaxic surgery as well as by other means.

Not all patients who are seen will be candidates for this study. In all cases, the selection of procedure will be made purely on the basis of clinical judgments according to the best information available up to that point in the study. It is hoped that as the study progresses the selection of patients and appropriate target points will become more efficient than is now possible.

Cooperation is also requested to obtain postmortem brain specimens from those patients included in the study who die later at other institutions, either of their disease or others causes. —Philip L. Gildenberg, M.D., Cleveland Clinic, Cleveland

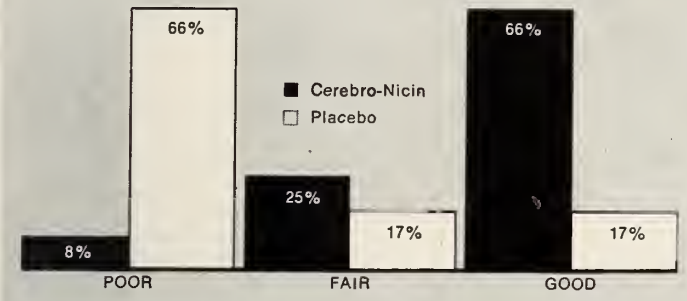
TREATMENT OF ACNE VULGARIS. — Fifty-one patients with acne vulgaris were included in a double-blind trial to assess the therapeutic effect of 250 mg. tetracycline hydrochloride twice daily for three months. The results, assessed clinically and photographically, showed that tetracycline hydrochloride had a statistically significant beneficial effect. Hence, since it is cheap and rarely has side-effects in healthy young adults, its use is suggested, as well as local therapy, in the more severe forms of acne.—Peter Lane, M.R.C.P., and Donald M. Williamson, M.D., Leeds, England: *British Medical Journal*, 2:76-79, April 12, 1969.

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CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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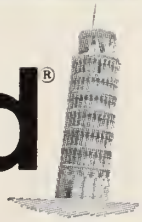
in the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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(thyroid-androgen) tablets



Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Contraindications—Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med S-67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-93.

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Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: tablet 3 times daily.
Available:
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Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
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Each orange tablet cantains:
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Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
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Each white tablet contains:
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Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
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Heart Pages

In few fields has the clinician been faced by a more rapid and prolific development of new concepts and technics than in that of cardiovascular disease. Anyone who completed his formal training ten to twenty or more years ago would be ill-advised to rely upon that training in his service to patients with heart disease in 1970.

A few years ago, with this in mind, *The Journal* published a series of excellent papers on cardiovascular subjects. These Heart Pages were written by Ohio authors and were made available to us through the cooperation of the Ohio State Heart Association. They were well received, but as it does so often, this well of local talent ran dry, and we have been without a Heart Page since July, 1968.

Now, the American Heart Association has made available to us through the Ohio State Heart Association a new series of articles by authorities from throughout the country. These exhibit the same characteristics we sought in the previous series. Not only are they authoritative, informative, and pertinent to the daily work of most of us, but also they are concise, to the point, and easy to read and to comprehend.

Everyone associated with this project deserves commendation, especially the authors and Dr. Philip Samet of Mt. Sinai Hospital, Miami Beach, Florida, who edited the papers. We feel this is a superb form of continuing education for physicians, and we are happy to resume the Heart Page with such excellent material. Seven of these papers appeared in *The Journal* for February, 1970. With this issue, we shall begin publication of one paper from the series each month. Happily, we have on hand a supply sufficient to continue for several months. We have been assured that the American Heart Association plans to continue this superb project indefinitely.

The Julie Geehr Mather Fund has been established in the Toledo area to promote research regarding lupus erythematosus. The long-term endowment fund was established through a donation by George Mather, of the Owens-Illinois Technical Center in Toledo, in memory of his late wife. The principal endowment fund will be maintained by a foundation of the Medical College of Ohio at Toledo.

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

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The antihypertensive therapy that is easy to live with.*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

Easy-to-live-with control. Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

*Salutensin is usually well-tolerated (however, serious side effects can occur; see adjacent column for brief summary of prescribing information).

Easy-to-live with dosage. Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

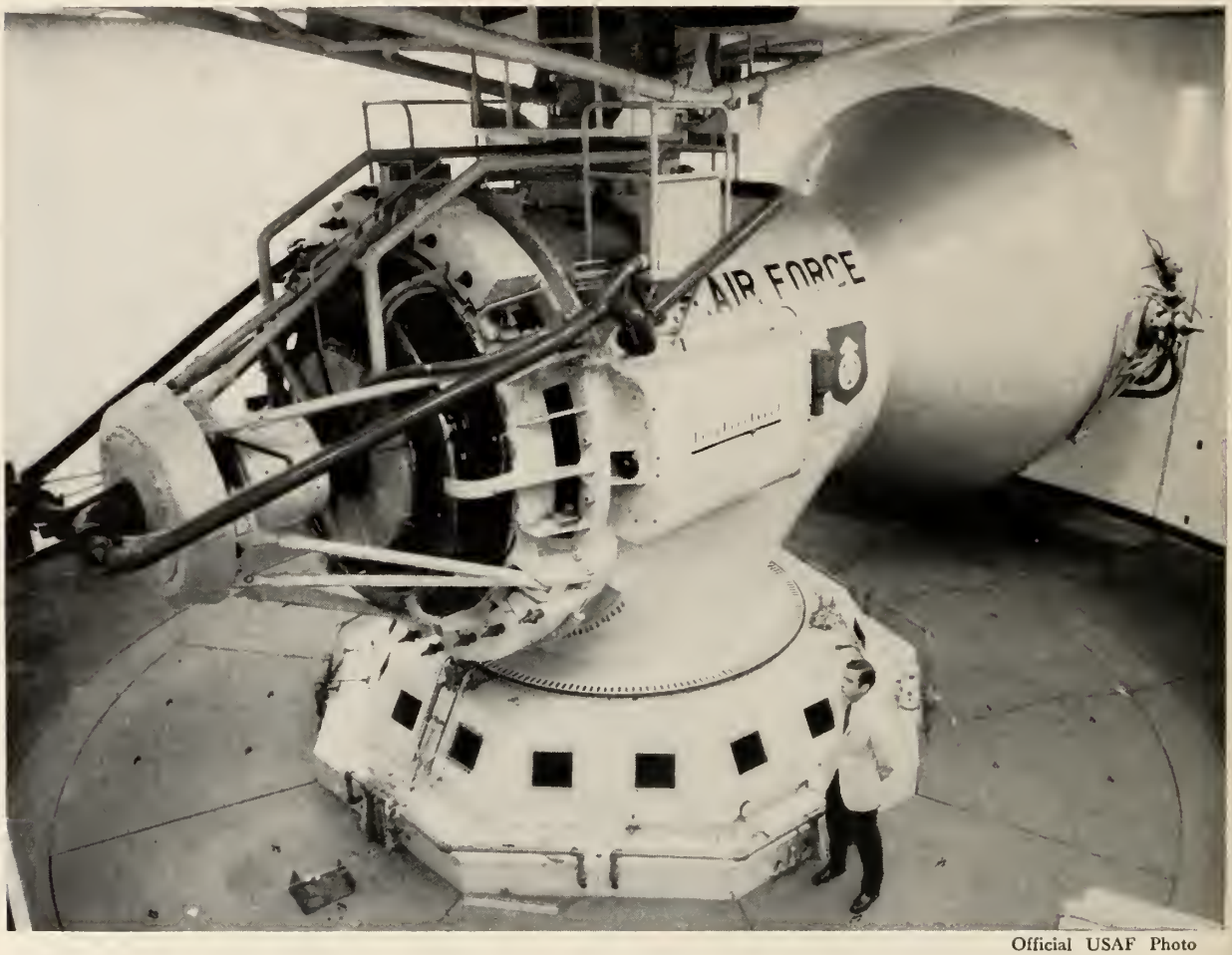
Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

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Ohio Physician Tests Aerospace Research Device



Official USAF Photo

The huge new multi-stress device dwarfs Dr. Michael McCally at the Aerospace Medical Research Laboratory at Wright-Patterson Air Force Base near Dayton, Ohio. First to ride the device, Dr. McCally heads the Aerospace Medical Research Laboratory's Environmental Medicine Division at the base and is a graduate of the Case Western Reserve University School of Medicine. The sophisticated centrifuge, called a Dynamic Environment Simulator, is designed to determine the tolerance limits of the human body to a variety of environmental conditions that exist in high-speed aeronautics as well as in aerospace flight.

Ohio AFB Pioneers in Space Medicine Research

A huge multi-stress device called a Dynamic Environment Simulator now is in operation by the Air Force at Wright-Patterson Air Force Base, Ohio, following completion of man-rating tests.

First to ride the device was a research physician, Dr. Michael McCally, who heads the Aerospace Medical Research Laboratory's Environmental Medicine Division at the base. The initial manned run was made on December 19, 1969.

The large, sophisticated centrifuge has a rotating mass of 180 tons and was designed to determine tolerance limits of the human body to a variety of environmental conditions that exist in high speed aircraft and in space flight.

The DES is unique in that it can investigate a variety of stresses, including vibration, heat and acceleration at the sime time. Previously the Air Force has studied stresses singly, but it virtually has been impossible to test a number of stresses simultaneously.

It is also unique in another respect. It is the first centrifuge that can be fully controlled either manually or by a digital computer. The control system, which was designed by the Raytheon Company, is capable of programming an entire experiment on tape. Also it provides real-time visual displays of the forces exerted on the subjects and of other conditions in the gondola, while the physiological responses of the subjects are recorded over as many as 400 signal channels.

Either the medical monitor or the operator of the machine may terminate an experiment at will for medical or other reasons. Elaborate safety devices protect the subjects from harm.

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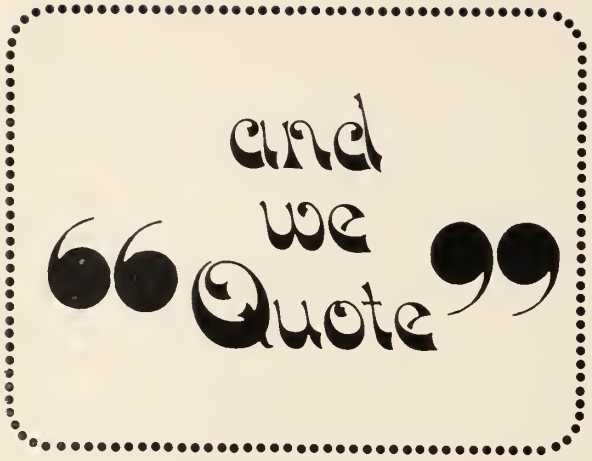
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Potential Medical Problems Related to Overpopulation

". . . The basic issues are relatively simple and few in number. It is clear we do not yet have at hand the ideal methods to limit the birth rate so as to maintain an appropriate state of equilibrium. However, while we await the more effective measures, much can be done with those now available. Medical students and physicians must understand the issue clearly and be familiar with the facts of birth control and the problems yet to be solved. Above all, they must develop a sense of urgency about the problem, which because of their strategic position in society, they may communicate to the populace at large. I would suggest that medical educators have an important role in this regard which in the past, with only a few exceptions, they have utterly failed to accept or recognize. Furthermore, we had best be accepting the possibility that there may be a significant change in the medical problems of the world directly related to overpopulation. . . ." — Frederick C. Robbins, M.D., Dean, Case Western Reserve University School of Medicine, quoted in excerpt in the *CWR Medical Alumni Bulletin.*

Sees Peer Review Gap in Continuing Education

"Another area of peer review where the profession has fallen down is in the area of continuing education for physicians. A large number of physicians keep current, but there is no provision to prevent numerous exceptions. Leadership has been exerted in providing for courses but, unfortunately, the licensing boards and the specialty certification boards have done little or nothing to require the updating of physicians' knowledge which we all know is required to maintain high quality of care. The American Academy of General Practice is an exception. The entire profession can follow the lead of AAGP which at least has addressed itself to the problem of review of current knowledge by which the academy reviews the educational preparation of its members." — Kenneth E. Rowe, M.D., in *Michigan Medicine.*

What He Has Done with What He Has Had

"Certainly we must change standards, for the present ones are in themselves discriminatory! But this does not mean that we must lower them. The best way to predict what one is going to do is to look at what he has done with what he has had. . . ." — David Satcher in the *Case Western Reserve Medical Alumni Bulletin.*

Advocates More Young Men for the Nursing Profession

". . . Government figures show that of more than 1,000,000 living professional-nurse graduates in this country, only half are in practice, and nearly 70,000 of whom work only part time. One of the principal bottlenecks to progress in nursing education is the lack of qualified applicants. . . .

"Why are there so few male nurses? Why is there a ratio of about one male to 20 female nurses? Tradition, perhaps as much as any factor, hinders the recruitment of men for careers in nursing. Nursing is still considered by many to be exclusively a woman's job. But men do make excellent nurses as any physician can testify who had army medics or navy corpsmen work under him. . . .

"Physicians should encourage more young men to join the ranks of the nursing profession and should give their wholehearted support to programs that will achieve this purpose.—*Massachusetts Physician,* February, 1970.

Seeking Change in an Evolutionary Manner

"Change is the most changeless fact of life. A. N. Whitehead has said, 'The art of progress is to preserve order amid change and preserve change amid order.' Please use your influence with the legislators for an organized approach on sound planning in an evolutionary manner rather than a radically revolutionary one. We can win if we understand Robert Frost when he said, 'Something we were withholding made us weak until we found

out it was ourselves.' The shackling of our profession can occur only if there are enough weak physicians who do not assume public responsibility in the significant 70's." —Walter L. Cawood, M.D., President of the Kentucky Medical Association.

"Glory Has Fallen to Others" in Population Control Field

"The history of 20th-century medicine is full of great achievements in many areas, but with respect to confrontation of the medical and social aspects of the expanding population it is shamefully wanting. The role of leadership which doctors could have carried with glory has fallen to others. Time is running out.

"Many countries have to choose realistically between having a really effective program of family limitation—or continuing with a stagnate situation with high rates of infant and child mortality, many stillbirths, and all the human tragedy and waste which these involve. Nature's way of keeping the numbers down is cruel and horrendous. . . ." — Dr. C. C. de Silva, of Ceylon, in *Clinical Pediatrics.*

The Spirit of Man—Intimate, Vulnerable, Indispensable

"The learned professions are not in danger of becoming extinct, they will always be needed for their technical ability; but they are in danger of becoming petrified.

"If the learned professions are to be dynamic, what is the way? It is as it always has been. We must listen with our hearts as well as with our minds. We must listen not as technicians, but as men wise enough to be all that we can for these people. If we do, we will have reached the real goal of our professions which is to develop the full capacity of each man, woman or child we are privileged to share a confidence with. We grow each time we do, for we learn how intimate, how vulnerable, how indispensable is the spirit of every man." — Ralph Crawshaw, M.D., in *Private Practice.*

Broad Implications of Organ Transplantation

"No longer is anyone unaware of the transplantation of organs, dramatized especially in the lay press by the worldwide efforts to successfully transplant the human heart. No matter what the doctor's specialized interests, he probably can not escape the need of answering questions to satisfy the curiosity of patients, acquaintances, friends, and family. . . .

"Today we are reminded always that medicine must not only be involved in scientific details of medical care, but of the patient as a 'whole,' and also that medical care must be viewed as it affects society. . . ." — R. H. K. in the *Southern Medical Bulletin.*

Tomorrow—That's too Late for Government Action

"By the time this editorial appears in the *Journal,* the great and controversial question of the cyclamates will probably be threadbare. In fact, it became old inside of about two weeks. . . ." — *Rocky Mountain Medical Journal.*



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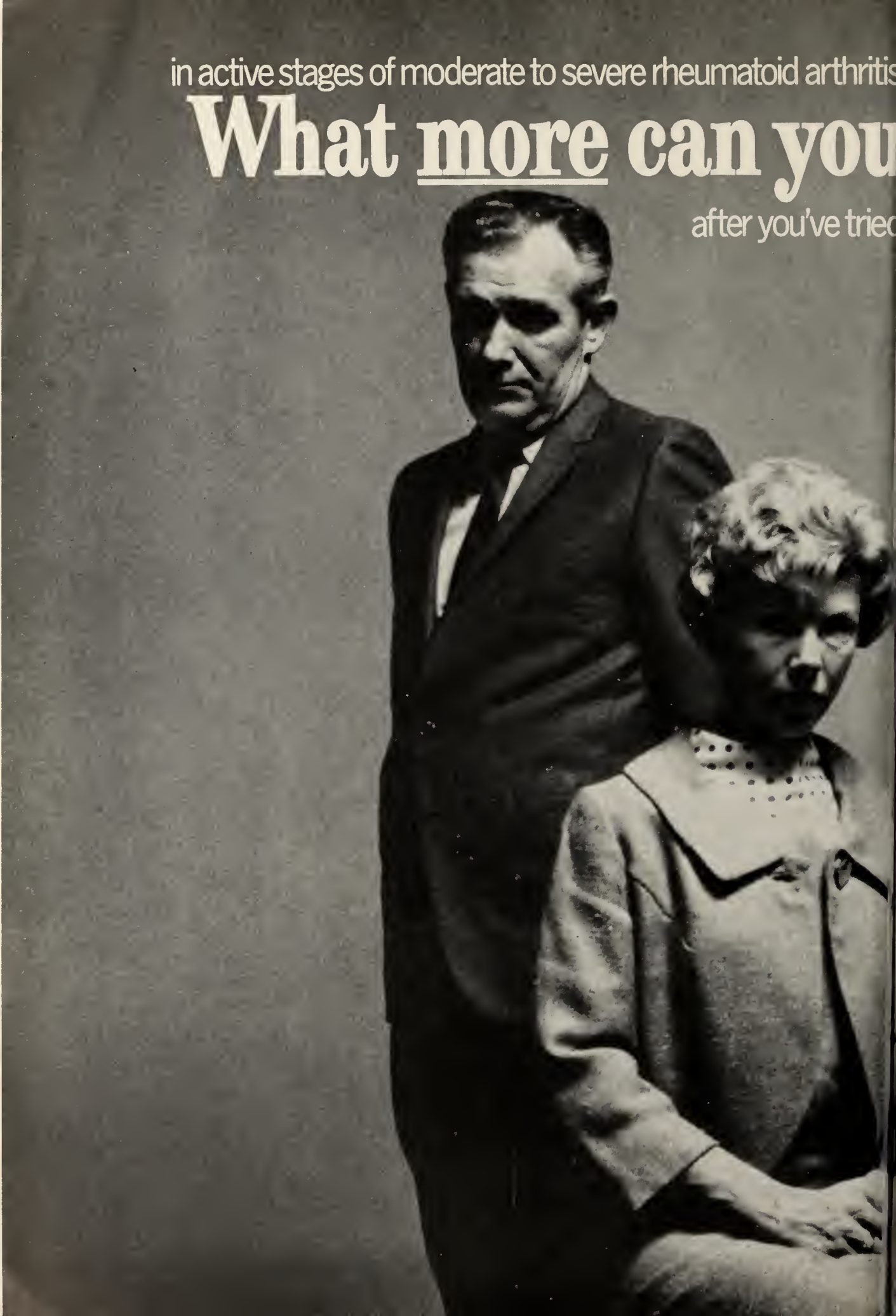
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in active stages of moderate to severe rheumatoid arthritis

What more can you

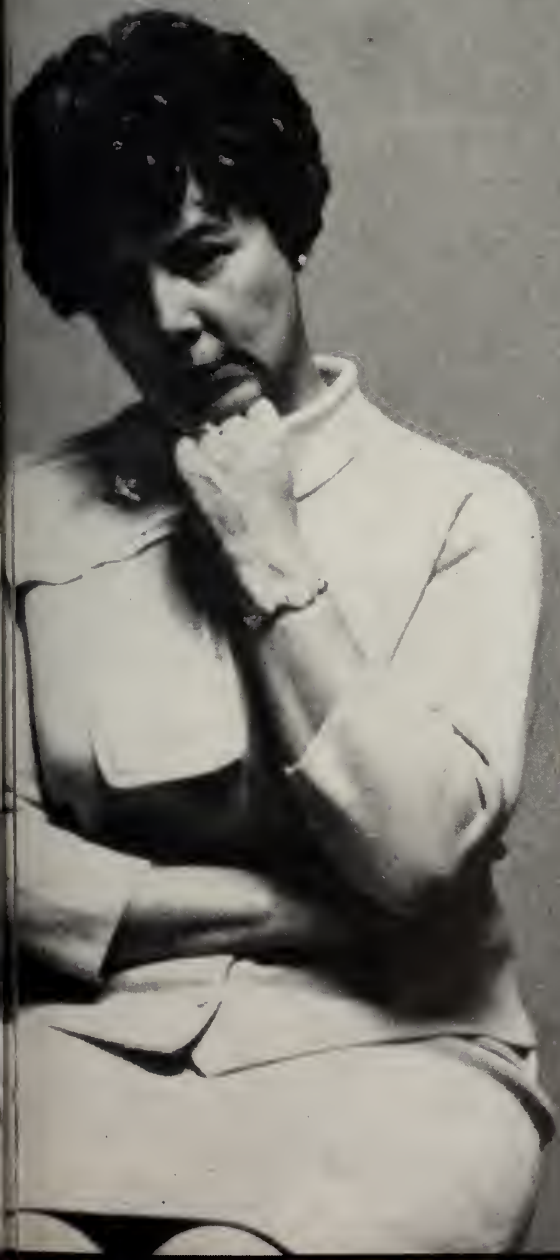
after you've tried



rheumatoid spondylitis, and osteoarthritis of the hip

do for these patients?

salicylates and rest



INDOCIN®

(INDOMETHACIN | MSD)

helps relieve pain, fever,
swelling, and tenderness

Please see new prescribing information on following page.



REVISED PRESCRIBING INFORMATION

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness, tinnitus.
Central Nervous System Reactions: Psychotic episodes, depersonalization, depression, coma, convulsions, peripheral neuropathy, drowsiness, mental confusion, lightheadedness, dizziness, headache.
Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

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Standards of Early American Medical Education

Donald E. Pitzer, Ph.D.

PART II

(Concluded from April Issue)

During the years from 1833 to 1868, there was no law in Ohio regulating medical practice.[14] After October 1868, Ohio doctors were supposed to present a certificate from a state or county medical society or a diploma from any domestic or foreign school of medicine to be licensed. An effort to improve the law in 1880 required that the diploma be from a medical school issued after attendance at two full courses of at least 12 weeks each.[14] In 1885, this was amended to provide that the diploma must be from a "reputable school of medicine."[14] Actual practice in licensing often fell sadly behind the ideals of the most lenient laws throughout the United States. Before the late 1880's, when state medical boards with the needed authority were established, enforcement of licensing laws, even when the laws were relatively strong, was nearly impossible.[11] An 1890 nationwide survey made by the Illinois State Board of Health showed that the Ohio law on medical practice was inactive at that time.[13] The lag of Ohio law and enforcement behind that of its neighboring states, particularly to the east and west, encouraged the ill-prepared to gravitate to the Buckeye State.[15] The Ohio State Medical Society, which had been formed in 1846, continually strove to attain better laws along with their implementation, but the task of awakening a lethargic public was not easy. Success finally came in February 1896 when the Ohio State Legislature followed the lead of 31 other states and established the Ohio State Board of Medical Registration and Examination.[7]

The first Ohio Medical Board consisted of two homeopaths, one eclectic, and one physico-medical practitioner, in addition to three regular physicians. By the next year the board resolved into the composition it retained until 1936; three regulars, two homeopaths, and two eclectics. Licensing was then established upon the basis of the payment of a $5 fee and the presentation of credentials. Between 1890 and 1900, acceptable credentials consisted of a diploma from a medical school recognized by the state medical board or proof of ten years of continuous practice of medicine in Ohio. One hundred and forty medical schools at home and abroad were rated in good standing by the original board. The board immediately approved licenses for approximately 7,000 physicians on the basis of their medical education and for another 700 under the ten years of practice provision.[7] The intent of the law, which was enacted in 1896, was to give recognition only to those practitioners whose qualifications were found satisfactory. That the law was sorely needed was attested by the president of the first medical board, who stated that "it is probable that no equal territory contained so many vampires, charlatans, mountebanks and quacks as did Ohio."[15] That the law was almost immediately effective in raising medical standards in Ohio was demonstrated by the fact that in two

years after its passage four medical colleges had been closed, 369 applicants for practice had been rejected, and as many as 700 "doctors" had left the state.[15] In May of 1900, provision was made that all candidates for licenses be required to pass an examination in all branches of medicine before the state board. The right to examine men for licensing became a valuable tool in the hands of the state board to limit the field to competent doctors. Other forward-looking requirements were also appended to the Ohio law at this time. These ideally required a four-year medical school diploma or an A.B., B.S., or "equivalent" degree from a reputable college to practice medicine. But the law would still settle for "a diploma from a normal school, high school, or seminary, issued after four years of study; or a teacher's permanent or life certificate; or a student's certificate of examination for admission to the freshman class of a reputable college; or a certificate of his having passed an examination conducted by the Board itself."[16]

The securing of state medical boards was the most effective action taken in the late nineteenth century to raise medical standards. Their principal functions were to upgrade preliminary educational requirements for entrance to medical schools, to evaluate the faculties of the schools, and to examine candidates for licensing. However, even after the start of the new century, state boards were only partially effective. Abraham Flexner in his 1910 report concluded that none of the state boards was "properly constituted, organized, and equipped."[4] Boards were afflicted with several chronic ailments. In some states, the laws were too weak to allow the boards to act decisively. Where there were adequate laws, some boards remained inactive because of the apathy of public opinion. In other cases, the boards were weak due to the fact that appointments to them were part of the political spoils system or that teachers were excluded from membership. Numerous boards were simply unwilling to antagonize the schools, but others were found by the Flexner study to be "cunning, powerful, and closely aligned with selfish and harmful political interests."[4] An inherent weakness of many boards was their organization. In these instances, the whole weight of responsibility rested upon one executive officer, the secretary. Nevertheless, reform was the watchword of the Progressive Era, and gradually rising medical standards were in vogue.

Reforms of the Educational System

Credit must be given to those schools and faculties which took the courage to initiate reform of the educational system internally. The pioneer in the movement to lengthen and grade the medical course was the Chicago school, which by 1910 became the medical department of Northwestern University. In 1859, it set up a three-year graded course.[4] This was a significant step in the right direction, but not until ten years later was this idea put into practice in many schools. In 1891, excluding Belgium, the United States was the only country in the modern, Western world in which an M.D. degree and a medical license could be secured without three years of study.[13] Graded courses were introduced into the Harvard Medical School curriculum in the early 1870's.[4] Rising entrance requirements often accompanied the revision of curricula. The schools leading such reform efforts were top ranking ones in the nation by 1900. The chief innovation was the requirement of two years of college with an emphasis upon science in preparation for medical training. In 1900 there were not more than 16 such schools in existence, but their impact upon the medical values and standards of the following decades was gratifying.[4]

Significantly, without exception these medical colleges were affiliated with universities. It was the completion of a cycle. Once more medical education in the United States would enjoy the intellectual, economic, and geographic stability of a university base. Because students were much better prepared by a background in science upon entering these schools, an advanced program of medical instruction became feasible. Coupled with this advantage was the provision of better laboratory facilities and a renewal of a close association with hospitals in which adequate clinical instruction could be given. These medical institutions, representing 22 of the 147 schools of medicine in the United States in 1910, were usually equipped well enough to give laboratory instruction in all of the popular medical sciences including bacteriology.[4] University funds made such facilities possible, but the lower ranking schools of the commercial type continued to refuse to buy such equipment in order to have profits from student fees to divide among their faculties.

Nearly all of the reforms in American medical education had been effected after 1880, and the most significant accomplishments came after 1890.[13] In most of the medical schools by 1900, didactic teaching had been reduced to its proper proportion in the curriculum, at least some clinical instruction was being offered, laboratories were in greater use and were better equipped, partially or fully graded courses were rather common, and the four-year course was not unusual.[4] These advances along with the vital raising of entrance requirements eradicated most of the abuses of the commercial schools. To properly equip a medical school allowed little if any profits to its owners and, therefore, not only discouraged the founding

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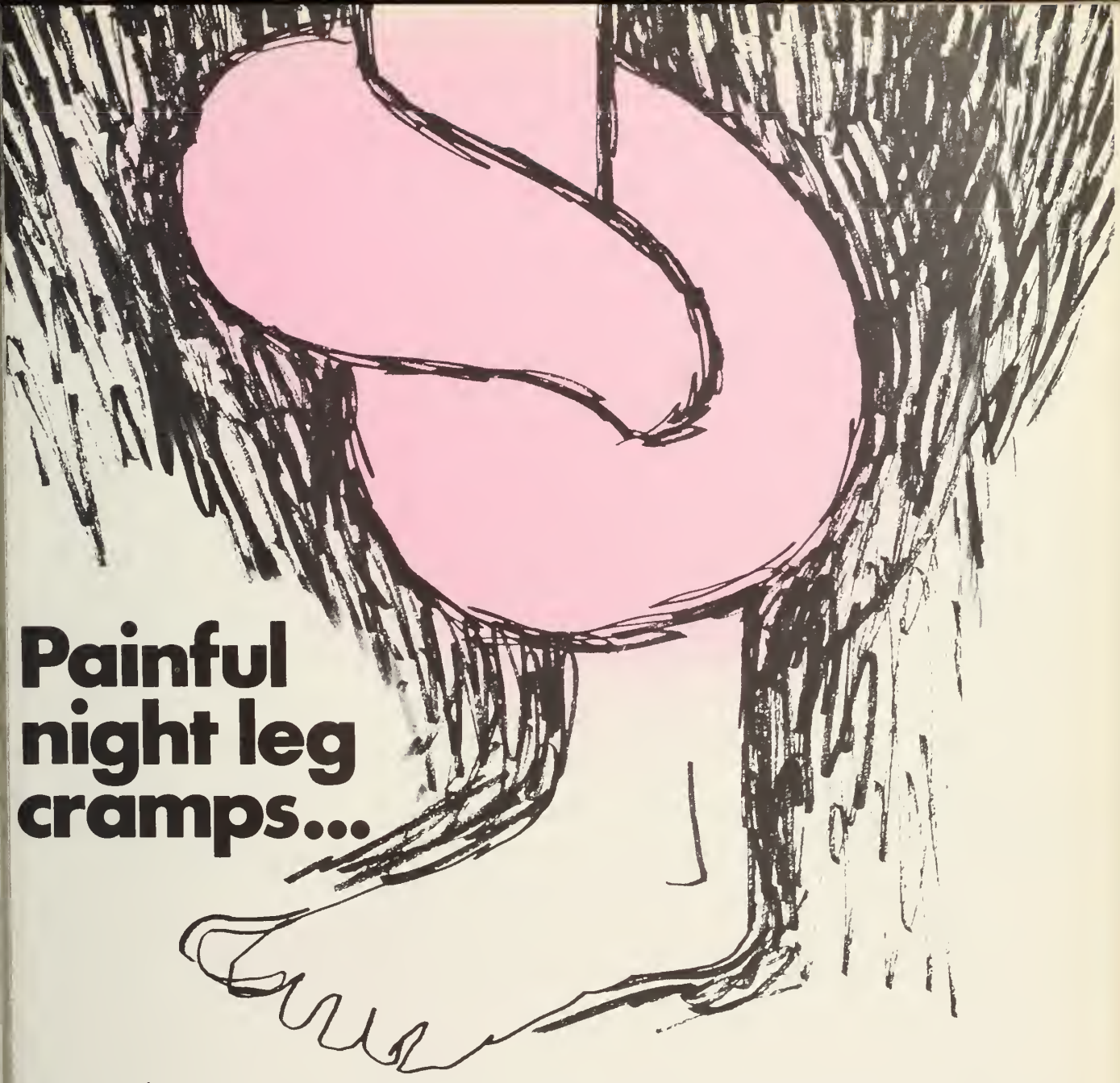
of new proprietary schools, but also caused many of the old ones to close their doors. The respectable independent schools after 1900 became intensely interested in becoming affiliated with universities in order to maintain their standards and their solvency. One of the most significant achievements of the reform movement had been the creation of state boards to regulate medical schools and to license physicians. Although even by 1900 many of these boards were ineffective, they were a source from which important reforms and sound standards eventually would emanate and be enforced in the twentieth century.

The Flexner Report

The nineteenth century of backward American medical standards and education came to a close in 1910 rather than 1900. 1910 was a decisive watershed in American medical history because of the critical and objective Flexner Report to the Carnegie Foundation, which was published in that year. It would be difficult to overestimate the impact of that report. The impetus for the Flexner investigation came from the American Medical Association, which in 1904 began an inquiry into the standards and facilities of medical schools through the Council of Medical Education. Although this council did some apropos research, it aroused much resentment among the schools which it examined. Because of this, the completely impartial Carnegie Foundation was asked to conduct the survey, which yielded the revealing Flexner Report of 1910.[11] This study traced the historical development of medical education in North America, gathered data on current medical resources, facilities, and methods and presented goals for which medical education should strive.[17] In effect, Abraham Flexner served as the muckraker of the medical profession. By exposing the deplorable truth about commercially dominated medical education, his report, together with the financial support given by the newly founded Rockefeller and Carnegie Foundations to medical colleges, inspired the reformation that produced the beginning of the Golden Age of Medicine in America.

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New Pamphlet Explains the AMA to the Public

A pamphlet of considerable value to medical societies in their public relations programs has just been released by the American Medical Association. In its 32 pages are outlines of many public services to protect and advance the health of Americans and the world population.

"The American Medical Association—Guardian of the Nation's Health Since 1847" summarizes its history and organization. Its real value in contemporary society, however, is in relating the many programs and the cohesive efforts of almost 220,000 member-physicians to promote better health care.

In the foreword, Ernest B. Howard, M.D., executive vice president of the AMA, wrote that the AMA since its founding in 1847 has instituted reforms, improved and expanded medical knowledge worldwide, and has achieved a place of recognized leadership.

Doctor Howard emphasized that the association serves not only its membership, the medical community, but also the public, and this pamphlet is intended to illuminate these services "to effect a broader understanding of the association's total functioning."

The booklet is intended for distribution to public audiences, but it serves equally well as a "refresher" for physicians and a "primer" for medical students and new society members.

It is especially effective as a "backgrounding" reference for editorial writers, media commentators, and community leaders.

It reviews the AMA's scientific meetings, publications, library and record services, medical student and school scholarships and grants, ethics, drugs, mental health, and health manpower recruitment activities.

The entire booklet is updated, and several new programs are covered: Volunteer Physicians for Vietnam, the Vietnam Medical School Project, the new Department of Health Care Organization (to accelerate health care delivery systems), proposing and drafting legislative bills, and the innovative proposals of the AMA Committee on Health Care of the Poor.

Other areas with increased emphasis reflect the problems of modern society: alcoholism and drug dependence, health care costs, malnutrition, pollution, sex education, and voluntary health insurance coverage.

Copies of "The American Medical Association—Guardian of the Nation's Health Since 1847" are available without cost from Program Services Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

MDs in the News

Dr. Chester H. Allen, Portsmouth, has been named a member of the newly created Governor's Committee on Employment of the Handicapped.

Dr. Lawrence J. McCormack, Cleveland, was elected vice-speaker of the Assembly of the College of American Pathologists at the organization's fall meeting in Chicago.

Dr. Stanley O. Hoerr, chairman of the Division of Surgery at the Cleveland Clinic Foundation, has been elected second vice-president-elect of the American College of Surgeons. He is a past president of the Ohio Chapter of the college and is serving his third three-year term on the Board of Governors.

Dr. Bruce G. MacMillan, chief of staff of the Shriners Burns Institute, in Cincinnati, represented the U.S. Department of Health, Education and Welfare as consultant and adviser on proposed burn research projects in India and Pakistan. He visited facilities in those countries on a 30-day tour.

Dr. Benjamin B. Caplan, Columbus, was named Man of the Year by the Brotherhood of Agudas Achim Synagogue and was honored at the third annual Flowers for the Living program sponsored by the organization. In addition to his active work in behalf of the Hospital Ship HOPE, he recently headed a team which administered immunizations among children of Bolivia.

Dr. Thomas F. Moriarty, practicing physician and former city councilman, took office as mayor of Napoleon on January 1.

Dr. Sarah Ann Nunneley, first woman physician to enter residency training in aerospace medicine at Ohio State University, has been awarded an Amelia Earhart Fellowship for continuing advanced studies in aerospace sciences by Zonta International.

Dr. Richard L. Wenzel, recently associate professor of public health administration at the University of Michigan, is the new health commissioner of Toledo. He is a native of Marietta, received his medical degree at Ohio State University, and a master's degree in public health from the University of Michigan.

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Clinical & Scientific Features

Volume 66 May, 1970 Number 5

Civilian Ureteral Gunshot Injuries

David J. Albert, M.D., Duane E. Banks, Jr., M.D., and Lester Persky, M.D.

WITH AN ALMOST geometric increase in the number of gunshot wounds in the civilian population of our large cities, ureteral injury, while still relatively infrequent, is being reported with increasing frequency. In a review of the literature by Howley, there were 52 cases of documented ureteral injury secondary to penetrating external violence of any kind prior to 1935. After 1935, he was able to find an additional 83 cases to which he added two of his own. In 1946, Culp reported 11 gunshot wounds of the ureter, representing all of those sustained during[2] World War II. In 1947, he reported 160 cases of urologic trauma admitted to a large hospital in the European theater and found no bullet wounds of the ureter.[3] Heller and Hubay reported 60 gunshot wound patients who underwent abdominal exploration during the period 1963 to 1968 and they found the ureter involved in only two cases.[4] In spite of the rarity of this injury, we have encountered five ureteral gunshot injuries admitted to the University Hospitals of Cleveland in the past five years.

The paucity of reported cases of this particular injury seems related to both the anatomic location of the ureter and to the concomitant trauma that must of necessity, be sustained in order for it to be injured. The ureter, in it's well-protected station, is endowed with mobility and is a particularly small target area. When an errant bullet does disrupt ureteral continuity, it almost invariably produces associated trauma to the abdominal or thoracic cavities, and this of such a nature as to obscure the ureteral injury. Death often results from wounds of this magnitude, and the ureteral injury, while not ordinarily the cause of death, goes unrecognized until autopsy. In the five cases to be reported and in those reviewed in the literature, one is struck by the frequency with which the ureteral injury is overlooked preoperatively and even during surgical exploration. The significance of this in terms of morbidity and loss of kidney tissue is undeniable, and for these reasons, the following case histories are reported.

Submitted November 5, 1969.

The Authors

• Dr. Albert, Cleveland, is Assistant Professor of Urology, Case Western Reserve University School of Medicine; Associate Urologist, University Hospitals of Cleveland; a member of the Attending Staffs, Cleveland Veterans Administration and Metropolitan General Hospitals.

• Dr. Banks, Miami, Fla., was formerly Chief Resident in Urology, University Hospitals of Cleveland.

• Dr. Persky, Cleveland, is Professor of Urology, Case Western Reserve University School of Medicine; Director, Division of Urology, University Hospitals of Cleveland.

Case 1. A 26-year-old white man received a .32 caliber



FIG. 1. Retrograde urogram demonstrates massive disruption of right ureter with extravasation.



FIG. 2. Cavity injected through catheter placed in fistulous tract.



FIG. 3. Simultaneous retrograde urogram and nephrostogram shows loss of continuity without extravasation.



FIG. 4. Ten month follow-up excretory urogram shows nearly normal left upper collecting system with contrast outlining ileal segment of ureter.



FIG. 5. Excretory urogram 47 days following injury reveals extravasation for upper ureter.



FIG. 6. Sinogram outlines fistula and entire collecting system.

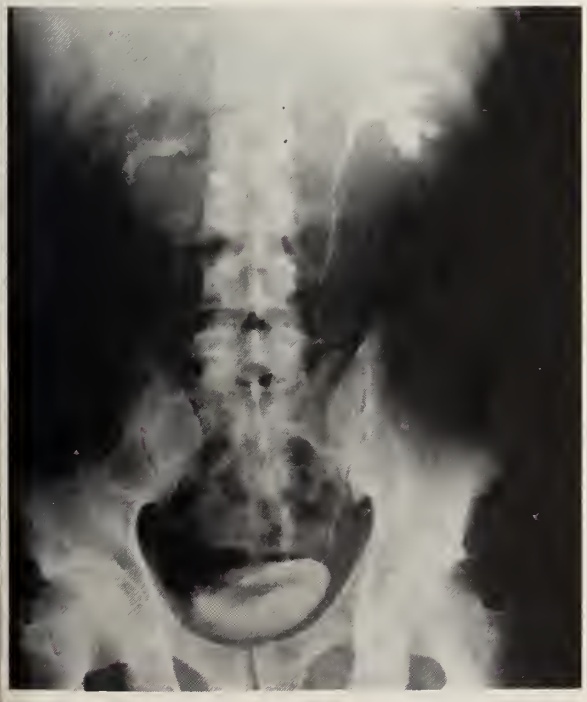


FIG. 7. IVP immediately following removal of splinting ureteral catheter. Small tract just below ureteropelvic junction persists.



FIG. 8. Excretory urogram two months following splinting shows intact ureter and minimal pelvic dilation.

bullet wound of the right lower quadrant in August of 1968. He was explored at another hospital, and six perforations of the small bowel were closed. Initially, there was no suspicion of urinary tract disruption. An excretory urogram, obtained on the third postoperative day, revealed extravasation of contrast material. He was reexplored, and the partially lacerated right ureter was sutured over an indwelling ureteral splint. When the splint was removed three weeks later, purulent uriniferous drainage developed through a fistulous opening in the flank.

Three weeks later, he was transferred to the Cleveland Veteran's Administration Hospital. A retrograde urogram revealed delayed excretion, hydronephrosis, and extravasation (Fig. 1). A small catheter could be passed into the fistulous opening, and injected contrast material outlined a large abscess cavity which communicated with the ureteral disruption (Fig. 2). Because of the marked scarring and extensive ureteral destruction. nephrectomy was necessary.

Case 2. A 14-year-old white girl was transferred to the University Hospitals of Cleveland 34 days after a .22 caliber bullet wound of the abdomen. The initial exploration required closure of multiple perforations of the small bowel and ligation of a severely lacerated left common iliac vein. On the 24th postoperative day, a retrograde urogram demonstrated extravasation from the left ureter about 12 cm above the ureterovesical junction. Exploration was required to remove 1500 cc of urine from the peritoneal cavity and the left proximal ureter was ligated. Following transfer to our hospital for evaluation of fever and flank pain, an emergency left nephrostomy was performed. Simultaneous retrograde and nephrostogram studies showed loss of continuity between the upper and lower segments (Fig. 3). Seven weeks later, a uretero-ileocystostomy was performed to replace the missing ureteral segment. An excretory urogram ten months later revealed a satisfactory result (Fig. 4).

Case 3. A 26-year-old Negro man sustained a .38 caliber revolver wound in the left upper quadrant in April of 1968. Exploration at another hospital reportedly revealed no internal injuries. He was readmitted to the same hospital 30 days later for incision and drainage of an intraperitoneal abscess. Forty-seven days after his injury, he was admitted to the University Hospitals with clear yellow drainage from his previous drain site. An intravenous pyelogram revealed massive extravasation from the upper left ureter (Fig. 5). A sinogram clearly outlined the fistulous tract as well as the ureter and renal pelvis (Fig. 6). A splinting, No. 6 ureteral catheter was placed cystoscopically and remained in place for ten days. The fistula closed spontaneously, and after removal of the catheter, only minute extravasation could be demonstrated by excretory urogram (Fig. 7). A follow-up study two months later revealed no extravasation and only mild pelviocaliectasis (Fig. 8).

Case 4. In January, 1969, a 45-year-old Negro man was shot in the chest, left lumbar area, and left abdomen with a .22 caliber pistol. A plain film demonstrates the location of the abdominal bullets (Fig. 9). At exploration, multiple perforations of the stomach were sutured, and a segment of jejunum required resection. A partial transection of the left ureter in its upper third was identified, debrided, and loosely approximated over a splinting ureteral catheter. A pull-out ureterogram ten days later revealed no extravasation (Fig. 10). An excretory urogram obtained two weeks after repair of the ureter demonstrated prompt function and integrity of both upper tracts (Fig. 11).

Case 5. A 21-year-old Negro man was shot with a .25 caliber bullet, which entered the left buttock and exited through the right lower quadrant. At exploration, repair of six small bowel lacerations and partial resection of the sigmoid colon were necessary. A complete transection of the lower ureter was repaired, and a drain was placed at the anastomosis. An intravenous pyelogram obtained two weeks later showed normal function of the left kidney with some urinary extravasation (Fig. 12).



FIG. 9. K.U.B. shows two bullets in the abdominal area.



FIG. 10. Ureterogram following repair shows continuity restored.

The leakage diminished clinically and the patient was discharged 16 days after his injury. Unfortunately, he has never returned for follow-up.

Discussion

The lesson to be derived from the literature and from these five cases is the frequency with which the injured ureter is overlooked preoperatively and at surgical exploration. Only one in our series had preoperative urography, and three of five had ureteral injuries unrecognized at initial laparotomy. The significance of this in terms of morbidity and eventual outcome is undeniable. Because the early manifestations of ureteral injury in a patient with multiple internal wounds are few and relatively silent, and because these injuries are not always apparent at surgery, a high degree of suspicion must be held in all such cases. An expanding collection of urine, fistulous drainage, infection, and urinary ascites all take time and the pain produced is usually masked by the more obvious trauma. Hematuria is an unreliable indicator of ureteral trauma and frequently is absent if this is a complete transection. The single most valuable study for evaluation of the upper urinary tract in gunshot injuries is the continuous infusion urogram, using from 60 to 120 cc of contrast material diluted with an equal part of 5 percent dextrose and water. Yet, as shown in our small series, this is a frequently omitted procedure in the press of life-threatening trauma. Undue delay in primary repair of the injury is often fraught with loss or severe deterioration of renal function. In addition, functional assessment of the contralateral kidney is of utmost importance when the surgeon is suddenly confronted with massive ureteral disruption first discovered at laparotomy.

Since every patient with a significant gunshot wound will presumably have a large bore intravenous fluid administration set in operation, no additional time will be lost by substituting contrast material for a portion of the required fluid load. If it is impractical to take films in the emergency ward because the patient must be taken promptly to the operating room, a single plain film of the abdomen obtained during anesthetic induction will almost always produce an excellent study of the upper tracts if high volume contrast material has been running. In less pressing circumstances, when venography or arteriography have been employed to assess the wounded patient, delayed films will serve adequately. When indicated, retrograde pyelograms may be of value in the more stable patient.

Summary

Because of its well protected location and small surface area, the ureter is rarely injured by external violence. However, when ureteral disruption does occur, it is frequently overlooked with a resultant high morbidity and loss of renal



FIG. 11. Infusion pyelogram four days after removal of splinting demonstrates prompt function without extravasation.



FIG. 12. Intravenous pyelograph two weeks following primary repair of ureter. Extravasation from lower left ureter persists.

function. Five cases of ureteral gunshot injuries, seen at the University Hospitals of Cleveland in the past three years are reported. A plea is made for a higher index of suspicion of ureteral injury and early diagnosis by means of high-dose contrast studies.

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DRUG ADVERTISING. — Whereas the relation between the drug industry and medicine is in some respects too close, excessive friendship between the industry and government is hardly a problem. To the contrary, the inimical confrontations that characterize exchanges between these two bodies benefit no one—and certainly neither the doctor nor his patient. In this hostile atmosphere, extremist accents are vociferous and loud. One such voice is that of Dr. James L. Goddard, who mounted an attack in *Esquire* that indiscriminately lumped together drug manufacturers, doctors, and many medical publications. And right in the middle of Goddard's line-up of bad men, what name should appear but that of *The New England Journal of Medicine.* The loud voices on the other side are no more conciliatory. On behalf of the Pharmaceutical Manufacturers Association, C. J. Stetler has issued pronunciamentos often richer in brickbats than building blocks. I am not too concerned, however, by the Goddard blast, for the cover of the *Esquire* issue in which it appeared seems to show pictures of Howard Hughes and his wife enjoying a swim in their pool. "We see you," boasts the caption, but according to *Time,* all we really see is models, a hoax to which *Time* granted the dubious achievement award. Articles, like men, may be judged by the company they keep.

The problem of drug advertising would no longer be a problem if the major parties concerned, government, industry, and profession, would be willing to compromise and to join in a common and united effort. Under such tripartisan sponsorship, one and just one authority with one set of standards would have the task—and the teeth—to ensure drug advertising that would be reasonable and unobjectional but yet would permit the advertiser to boost his product. Such a sponsorship might also assume responsibility for an authoritative and acceptable drug compendium.

The concept of medicine, pharmaceutical industry and government working together in harmony is probably impractically utopian. Yet there is no reason why the profession, the drug firms, and government should not work together in a unit structured for debate and ultimate parliamentary action. Some orderly system must replace the piecemeal decisions, the public hassles, and legal maneuvers that now appear to characterize the making, selling, and using of drugs.

That the groups involved will have conflicting points of view is inevitable, but their resolution, not their aggravation, will have to be the goal. Extremists identify problems. Sometimes they clearly precipitate them. But solutions must be sought and achieved by moderates.—Franz J. Ingelfinger, M.D., Editor, *The New England Journal of Medicine,* 281:532, Sept. 4, 1969.

Rhinorrhea and Otorrhea

A Review of 21 Cases

Larry D. Schoenrock, M.D., and Frank H. Mayfield, M.D.

CEREBROSPINAL fluid fistula is always a potential source of meningitis, and it would appear from the literature that mortality due to pyogenic meningitis from this source was high prior to the advent of the sulpha drugs and the antibiotics.[10] Traumatic fistula resulting in cerebrospinal fluid rhinorrhea and otorrhea are rather common. Spontaneous fistula due to tumor, hydrocephalus, etc., are fairly common. Surgically induced fistula from the transaural approach to the cerebellar pontine angle and from the transsphenoidal approach to the pituitary are seen in increasing numbers. But in spite of this increase, there is as yet no consensus as to proper methods of management and/or the indications specifically for surgical repair.

The purpose of this paper is to present the data from 21 consecutive cases treated during the period of 1950 to 1969 without a death, and of whom only nine required surgical repair, and to report in detail on three cases that present unusual and/or significant features.

Of the 21 cases, the fistula was through the ear in nine, through the nose in twelve. Combined otorrhea and rhinorrhea occurred in three cases. Trauma accounted for the fistula in 17 cases; 16 from fracture, one from a stab wound. A surgical procedure induced the fistula in three as the result of surgical attack on a tumor adjacent to a nasal or mastoid sinus, and one was spontaneous in origin through an empty sella.

This coincides with the order of frequency in reference to the etiological agent of most reports. The majority of authors report that spontaneous closure of a traumatic fistula will occur within one to two weeks. Ray and Bergland, however, in a recent report, record 53 patients with fistula who were observed at Cornell University over a 35-year period, all of whom required surgical repair.[11] Twenty-four percent of their cases had suffered meningitis, and seven percent had required a shunt procedure to control increased intracranial pressure before the leak could be stopped. They do not state the number who were treated before chemotherapy or antibiotics, or the number who were observed in which spontaneous recovery took place.

Of our 17 cases due to trauma, 11 healed spontaneously, six required surgical repair. The average duration of the leak for those who recovered spontaneously was 8.3 days; for those who required surgical repair, the duration of the leak varied widely. In one child, with a stab wound through the ear, surgical correction was under-

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taken within three days; in another, the leak had been present over a period of four years before repair was effected. Spontaneous healing of all cases of otorrhea due to fracture took place. When the fistula was through the nose as a result of fracture, spontaneous recovery was far less frequent. Five of 12 cases of rhinorrhea secondary to fracture required surgical repair. Meningitis occurred in nine cases.

Age and sex appear to have had little significance either on etiology or recovery. The youngest patient was 2½ years and the oldest 78, with an average age of 33 years. Six were female; 15 were male.

Detection of cerebrospinal fluid fistula is usually possible by identifying the sugar content of the escaped fluid. Anatomical location, however, may be difficult indeed in patients in whom surgical repair is contemplated. One must use with utmost skill not only skull x-rays, but tomography, pneumoencephalography, risa scan, the occasional injection of dyes, and/or air insufflation, as recently described by Ray and Bergland.[11]

Methods of Management

Our method of management for the acute fistula, either traumatic or surgical, has been quite simple. The patient is kept at bed rest with no effort made to control the level of spinal fluid pressure or to influence the flow of fluid by posture. The nose and/or ear is kept clean. Efforts are made to prevent coughing or straining, and an adequate screen of sulpha or appropriate antibiotics is maintained. The argument has been raised that antibiotics as a prophylactic are superfluous, since they do not effectively cross the blood brain barrier in the normal. Perhaps this is correct, but we have assumed that the continued leak might in some way alter the blood brain barrier so that the antibiotics do reach the cerebrospinal fluid, and we will continue to use them as long as our mortality rate remains as low as it is.

Fortunately, most cases of rhinorrhea and otorrhea close spontaneously, and unless the indication for surgery is overwhelming, we have elected to wait one month before considering surgical closure.

The first successful closure of a cerebrospinal fluid fistula, using an intracranial exposure and a fascia lata graft, was reported by Dandy in 1926.[6] Since that time, various technics have been adopted, and recently, in the excellent report by Ray and Bergland, successful operative closure was reported in 90 percent of cases, with 27 percent requiring more than one operation.[11] Patients with high intracranial pressure (hydrocephalus) may require a shunt procedure to insure closure of the fistula.

In three of our cases in which surgical repair was necessary, the fistula was in the region of the cribiform plate, and each was dealt with through a bifrontal craniotomy and an extradural approach along the roofs of the orbits bilaterally. By this method, the fistula was immediately identified and could be dealt with by closing the dura with sutures and implanting muscle over the bony opening. Two of the patients had undergone one or more operations elsewhere by the transdural route.

It is recognized that the fistula may be behind the sphenoidal ridge at times, or through the sella, and the specialized technics described by Ray and Bergland are recommended.

Case 1. *Otorrhea, post-traumatic, from puncture of the right eardrum.* A 2½-year-old white female was seen on September 15, 1952 because of right otorrhea. Three days prior to admission, the child had forced a bobby pin into the right internal auditory meatus and was found by the mother shortly thereafter with the bobby pin projecting from the ear. When it was withdrawn, there was a gush of cerebrospinal fluid from the ear. At the time of examination, a copious amount of fluid could be recovered, and drainage continued copiously. (Its sugar content was 64 mg. per 100 ml.) No air was noted in the intracranial spaces, and there was no evidence of infection and/or cerebral damage. The patient was treated with a combination of antibiotics. After otolaryngologic consultation, we were convinced that the wound was through the roof of the auditory canal with the dural perforation in the region of the middle fossa, and that it should be possible to reach it through a transtemporal approach. On September 16, 1952, right temporal craniotomy demonstrated a dural tear just lateral to Meckel's cavity. Methylene blue, which had been placed in the external auditory canal, appeared in the intracranial space at the site of perforation. Two large muscle grafts were placed in the bony opening and the dura which had been elevated was sutured. Within the first few hours after operation, small amounts of fluid appeared in the auditory canal, but within 12 hours, the leakage had definitely ceased, and it is believed that that which escaped after operation had been in the mastoid cells prior to operation.

Case 2. *Postoperative otorrhea.* A 47-year-old white female was seen in consultation on August 21, 1967 because of pain in the right lower jaw and tongue and severe vertigo. The patient's illness had begun in 1961 with an adenocystic carcinoma identified in the nasopharynx at the os of the eustachian tube. Surgical removal was followed by radiation. Initial treatment included surgical removal followed by radiation therapy. In 1965, the patient developed vertigo, progressive right facial paralysis, and pain in the right lower jaw. Radium implants were then used to treat the recurrence.

At the time of our initial examination in August, 1967, the patient was observed to have total paralysis of the right face, deafness of the right ear, loss of sensation over the right lower jaw and tongue, pain in the tongue, and atrophy of the muscles of mastication on the right side. Radiographic examination showed erosion of the petrous portion of the temporal bone. An angiogram showed displacement of the carotid artery medially as it emerged from the foramen lacerum. In view of the prolonged clinical course and the fact that the tumor was lateral to the carotid artery, removal of the gasserian ganglion appeared both feasible and necessary.

On August 29, 1967, through a transtemporal craniotomy, the gasserian ganglion was exposed and was found to be invaded with tumor, and the ganglion was resected except for a small portion adjacent to the first division of the fifth nerve. The tumor projected posteriorly into Meckel's cavity, and this was removed. Recognizing that the tumor had originally presented itself through the os of the eustachian tube and in view of

the facial paralysis, it was decided to follow the superficial petrosal nerve into the temporal bone for the dual purpose of identifying the facial nerve and also removing any tumor which coursed along the eustachian tube. The tumor was found to have projected into the labyrinth and to run along the course of the eustachian tube canal, and it was necessary to remove the labyrinth and the major portion of the bone overlying the eustachian tube in order to remove all visible tumor.

At the conclusion, we were confronted with a patient who had the entire external auditory canal open into the middle fossa and Meckel's cavity wide open, and a substantial rent in the tent at its point of attachment to the petrous ridge, the rent extending laterally from Meckel's cavity. Water-tight closure was impossible. An effort was made to reduce the dural opening by muscle tacks. However, when the patient left the table, copious otorrhea was present, and for three or four days the most copious escape of fluid that we have ever observed took place. The patient was kept on bed rest and antibiotics. On the fourth day, the volume of fluid lessened, and by September 6, nine days after operation, this had ceased. Since operation, the patient has been free of pain, the vertigo has been controlled, and there has been no further escape of spinal fluid. Our experience with this case leads us to believe that spontaneous closure of a fistula in traumatic otorrhea can always be expected.

Case 3. *Postoperative cerebrospinal fluid leak into the nasopharynx via the left eustachian tube following removal of a left cerebellar pontine angle tumor (acoustic neurinoma).* This 22-year-old white woman was first seen on March 3, 1968, following a syncopal attack. Subsequent evaluation confirmed the presence of a tumor in the posterior fossa, the most likely diagnosis being an acoustic neurinoma. On March 8, 1968, a left occipital craniectomy was done and a large tumor (8 cm.) was totally removed. In the course of the operation, one mastoid cell on the left side was entered and was covered with a bit of muscle. After the removal of the tumor, the dura was closed, though no special effort was made to effect a water-tight closure.

The patient's convalescence from the operation was totally uneventful, except for persistent discharge of cerebrospinal fluid from the left nostril. The amount of fluid escaping was small. The patient would appear to be free of the leak for several hours, and then perhaps one cc. of fluid would escape. Inspection of the ear gave no help in determining whether the escape of fluid was through the middle or frontal fossa into the nose, and otolaryngologists looking at the ostium of the eustachian tube could not arrive at a conclusion. The patient was treated with antibiotics and observed until May 1, 1968, without any cessation of the leak, and it was decided to reopen the wound. It was then shown that an escape of fluid through the midline made its way extradurally to the opening in the mastoid cell. Muscle and fascia implant over the mastoid bone and a direct graft of the dura effectively sealed the leak. The rhinorrhea was arrested and did not recur, but after one week, a fistula through the skin resulted in pyogenic meningitis. The patient was treated with Chloromycetin and penicillin, and by May 11, 1968, was symptomless and has remained well since. This was our first experience with rhinorrhea through the eustachian tube from a posterior fossa lesion.

Summary and Conclusions

This has been a review of 21 cases of rhinorrhea and/or otorrhea which have been evaluated and treated during the period from 1940 to 1969. Involved have been 15 males and 6 females, with an age range of 2 to 78 years. Seventeen of the cases were secondary to trauma, three secondary to surgery, and one of spontaneous occurrence.

Of the seventeen cases of traumatic rhinorrhea and/or otorrhea, six were treated surgically (35 percent); the remaining 11 were treated effectively with antibiotics and bed rest. An average of 8.3 days was required for those cases of rhinorrhea and/or otorrhea which terminated spontaneously. An average of 1.7 days was required for the termination of the rhinorrhea and/or otorrhea when surgical correction was used. An arbitrary one-month trial of bed rest and antibiotics was used prior to selection for surgical closure. Surgical closure was undertaken without a trial of bed rest and antibiotics only in those cases in which there was clinical evidence of unlikely spontaneous remission. Of the three cases of surgical etiology, two required subsequent repeat surgical closure. In the one case of spontaneous occurrence, antibiotics and bed rest were not effective, and surgical closure (x3) was required four years post-occurrence. As evidenced by case 3, drainage of cerebrospinal fluid from the nose is not pathognomonic of a fistula into the frontal or ethmoid sinus but may occur through the mastoid bone into the middle ear and the eustachian tube.

Generic and Trade Name of Drug

Chloramphenicol — Chloromycetin (Parke - Davis Company)

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Specificity of Symptoms of Extracranial Carotid Occlusive Disease

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In 1914, Ramsay Hunt noted that approximately one third of all cerebral infarctions were caused by arterial occlusion in the neck,[1] but prior to 1954, this information was of academic value only.

Since 1954, when C. G. Rob did the first carotid endarterectomy,[2] the operation has been widely used to improve cerebral blood flow. At the present time, the value of this procedure as a prophylactic measure in carotid stenosis is widely recognized. As a result, it is now necessary to evaluate carefully any symptoms of cerebral ischemia a patient might relate, to determine if extracranial vascular lesions might be responsible. After obtaining a careful description of symptoms, the physician must now examine critically the extracranial carotid system and decide if his patient is a candidate for carotid arteriography. On the basis of arteriography, the physician can determine if a patient has a remediable extracranial lesion.

We have evaluated in retrospect, the symptoms of 72 patients who underwent elective carotid endarterectomy at The Ohio State University Hospitals. Our purpose in doing this was to demonstrate that a large number of patients having transient attacks of cerebral ischemia and extracranial carotid lesions will present with rather classic complaints. If carefully elicited, these symptoms localize the symptomatic lesion quite accurately, leading to early diagnosis and remedial treatment before a cerebral infarction occurs.

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Materials and Methods

From May, 1960, through December, 1968, seventy-two patients underwent elective carotid endarterectomy at The Ohio State University Hospitals. Their case records were studied retrospectively, and the symptoms were tabulated for evaluation (Table I).

Symptoms that were clearly hemispherical in origin were considered to be specific for lesions

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occurring in the carotid system. These included transient monocular blindness, centralateral hemiparesis, aphasia, and sensory disturbances involving one half of the body. Symptoms that were questionably hemispherical in origin were considered suggestive of carotid lesions. These included monoparesis, unilateral sensory changes involving less than one half of the body, and alterations in speech, most commonly dysarthria.

The remaining patients were either asymptomatic or had symptoms not directly attributable to cerebral ischemia in the distribution of the proven lesion.

Results

A total of 42 patients (58 percent) had symptoms that were clearly arising in the distribution of a carotid artery. The most common symptom was transient hemiparesis on the side opposite the carotid lesion. It was found in the histories of 25 out of 42 patients.

The second most common symptom was transient ipsilateral monocular blindness, occurring in 14 patients. Only one patient of the 42 had experienced both symptoms.

Six patients related histories of transient sensory disturbances distinctly limited to both extremities and the trunk on the same side. Three of the six had additional specific hemispherical symptoms: two had transient monocular blindness and one had temporary hemiparesis.

Nine more patients (12.5 percent) had intermittent symptoms suggesting, but not specific for, ischemia in the distribution of the proven carotid artery lesion. Five of the nine had transient episodes of monoparesis on the side opposite the carotid lesion, while two patients had transient numbness in the contralateral arm. Dysarthria and stuttering were complaints of the two remaining patients, while one patient had brief episodes of both dysarthria and monoparesis. Of the nine patients, four had vague visual complaints such as transient episodes of blurred or dim vision.

Twelve patients (17 percent) who had widely variable nonspecific complaints of cerebral dysfunction were found to have significant extracranial carotid lesions that were surgically corrected. Their complaints ranged from bilateral upper extremity numbness to diffuse headaches. Five patients of the 12 had had either syncopal episodes or brief feelings of lightheadedness.

The remaining nine patients (12.5 percent) had no symptoms referable to the proven lesion. Three were admitted for evaluation of peripheral arterial disease and were found, on their admission examination, to have carotid bruits, leading to carotid arteriography. Three had bruits that were found by their personal physician on "routine" examination and two sought medical care because of "swishing sounds" in the ear of the affected side. One patient had a cerebrovascular accident in the distribution of the contralateral carotid artery and was subsequently found to have a bruit on his asymptomatic side.

TABLE 1. Frequency of Various Symptoms Encountered in Patient with Documented Carotid Artery Stenosis.

		No. of Patients	Percent of Total
Specific Symptoms		42	58%
Transient hemiparesis	25		
Transient monocular blindness	14		
Transient sensory disturbances	3		
Suggestive Symptoms		9	12½%
Transient monoparesis	5		
Transient sensory disturbances	2		
Transient speech disturbances	2		
Nonspecific symptoms		12	17%
No symptoms		9	12½%
		72	100%

Discussion

In reviewing the records of these 72 patients, we were somewhat surprised to find that 42 patients with proven extracranial lesions had either transient monocular blindness or transient hemiparesis: symptoms that are quite specific for occlusive disease in the carotid circulation. This finding suggests that a large percentage of people having symptomatic extracranial carotid occlusive disease will have specific symptoms. Hence, the occurrence of these symptoms should suggest the possibility of extracranial disease in any patient.

Especially surprising is the history of transient monocular blindness in 19 percent of the patients. This symptom is virtually specific for extracranial carotid occlusive disease since the ophthalmic artery is the first intracranial branch of the internal carotid, and it can be transiently occluded only by thromboemboli originating proximal to its origin.

In addition, the occurrence of transient monocular blindness is considered to be of important prognostic value by Drake and Drake, who noted a consistent statistical relationship between this symptom and the eventual occurrence of a major stroke in the same arterial system.[3]

The foregoing data also suggests that about 12 percent of patients with nonspecific symptoms of cerebral ischemia will be found to have significant extracranial carotid disease. Because of this, careful questioning and careful examination of the

great vessels in the neck are quite important in this group to select patients who might profitably undergo surgery to augment total cerebral blood and, possibly, to prevent development of a permanent neurologic deficit.

Careful evaluation and examination of patients having transient symptoms, as well as those who are asymptomatic, are extremely important since these patients comprise the group that benefits most from surgery[4] and since it is widely accepted that surgical intervention after the occurrence of a cerebrovascular accident is of little value.[5,6]

Adequate examination of the great vessels in the neck requires little time and can easily be done as part of a "routine work-up." On physical examination, patients with extracranial carotid occlusive disease, with or without symptoms, are usually found to have a bruit over the carotid bifurcation, which is located at the level of the superior edge of the thyroid cartilage. They may also have unequal common carotid pulses.

Since bruits are present in about 75 percent of people who have significant carotid occlusive disease,[7] they represent an important finding, deserving of careful evaluation. One must rule out other abnormal sounds occasionally heard in the neck. The findings most commonly confused with carotid bruits are transmitted murmurs, venous hums, and bruits originating in the thyroid gland. The possibility of a sound heard in the neck being a transmitted murmur may be ruled out by careful evaluation of the equality and radiation pattern of any heart murmurs. In addition, most cardiac murmurs occur early in systole while carotid bruits usually start in mid or late systole and occasionally extend into diastole.[8] Venous hums, which usually occur in young people, are continuous, reach maximal intensity in diastole, and disappear in the recumbent position. Bruits of thyroid origin occur in an abnormally vascular gland, usually in patients with symptoms of hyperthyroidism. Furthermore, carotid bruits due to atherosclerosis are best heard laterally in the neck, under the angle of the jaw, while bruits of thyroid origin are best heard over the gland.

In evaluation of a bruit, it is important to remember that it may disappear when the lumen is about 85 percent occluded. Thus, the absence of a bruit does not eliminate the possibility of there being significant disease in the artery in question. For the same reason, the severity of obstruction cannot be accurately estimated by the volume of the bruit. Quite significant, however, is the duration of the bruit. That is, a bruit extending through systole into diastole indicates that the degree of obstruction is so severe that there is a pressure gradient across it even in diastole. Patients in whom this finding is observed are considered to be closer to having total occlusion of the carotid than others with only a systolic bruit.

Since many believe that a stenosis of 50 percent or greater represents a physiologically significant lesion and since bruits generally appear at about this degree of occlusion, the presence of a carotid bruit, even in a patient without a history of transient cerebral ischemic attacks, is sufficient indication for carotid arteriography. This point is especially significant when one considers that 35 percent of patients having frank strokes will do so without ever having had premonitory attacks of transient ischemia. Similarly, any patient who gives a history of transient cerebral ischemic attacks of carotid origin should undergo arteriography, since 79 percent of them, if not treated, will eventually have frank strokes with a large percentage of these falling in the distribution of the carotid artery.

Results of arteriography show that 74.5 percent of patients having ischemic attacks had surgically accessible lesions, most commonly located at the carotid bifurcation.[9] Results of arteriography in patients having a carotid bruit and no ischemic symptoms show that 76 percent had arterial obstruction at the site of the bruit.

It is generally accepted that nearly all attacks of transient ischemia are caused by transient arterial occlusion by fibrin emboli.[10-12] Further evidence for this is the fact that transient attacks may be controlled by treatment with anticoagulants. It is a controversial question, however, whether anticoagulation has any effect on the eventual fate of patients having transient ischemic attacks. It is our view and that of others that the preferred treatment is carotid endarterectomy where possible and not anticoagulant treatment. Nevertheless, patients having symptoms of transient cerebral ischemia and no critically narrowed areas of arteriography are logically treated with anticoagulants.

Since the maximum benefit from carotid endarterectomy accrues to those with no permanent neurological deficit, it behooves all physicians seeing patients in the appropriate age group to question specifically for symptoms of cerebral ischemia on every "routine" work-up and to examine carefully the great arteries in the neck for hints of impending cerbrovascular accidents. By doing this, the physician can choose candidates for arteriography and, therefore, determine which of his patients has operable arterial disease. In this way, it might be possible to lower the heavy toll taken by cerebrovascular accidents.

Conclusion

The case records of 72 patients who underwent elective carotid endarterectomy at The Ohio State University Hospitals were reviewed. Forty-two patients (58 percent) gave histories of symp-

toms which clearly originated in the distribution of the carotid artery while nine more (12.5 percent) had symptoms suggestive of transient carotid insufficiency. It is concluded that specific symptoms are quite common in patients having attacks of transient cerebral ischemia. The importance of careful evaluation of the asymptomatic patient who represented 12.5 percent of our series is also discussed.

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THE FUNDAMENTAL DILEMNA has been beautifully caught by T. S. Eliot in *The Cocktail Party*. "I have realized," says Edward Chamberlayne, "that mine is a very unusual case." To this the psychiatrist replies, "All cases are unique—and very similar to others." In this subtle distinction, it seems to me, lies the difference between treating cases—"very similar to others"—and caring for sick people—every one of them unique. Can the impersonal health team of the future ever be a substitute for the personal physician? Will the individual patient with his human weaknesses, his hopes and fears, have anyone to confide in? We already have armies of highly trained auxiliaries, but precious few kindly ordinary people to help the sick. Our profession seems to be going the same sad way.

Every report born of a committee seems to be proclaiming the same insidious doctrine: "We shall replace relationship by organization; personal responsibility by regulation." The dead hand of bureaucracy is upon us.

Technologies—of which medicine is certainly one—should be a marriage of the human with the technical, not the imposition of science on society. The balance will be kept only if our profession takes the bureaucrats and planners firmly by their collective nose and drags them protesting along the right road. It is our task to show the way, theirs to administer the details. *Not* the other way round.—George Birdwood, Medical Journalist. Abstracted from *British Medical Journal*, December 20, 1969, p. 740.

Lipoma of the Corpus Callosum

A Case Report

Tearle L. Meyer, M.D., and Warren Leimbach, M.D.

A CASE of a lipoma of the corpus callosum associated with agenesis of the corpus callosum is presented. Only 70 such cases were recorded up to 1969 with most being associated with agenesis of the corpus callosum. The following case is of special interest as there were diagnostic plain films as well as an arteriographic and pneumoencephalographic study.

Lipomas have rarely been reported arising in the brain. Half of those which do occur in the brain are located in the corpus callosum.[15] The first case was discovered accidentally at autopsy by Rokitansky in 1856.[16] Zettner and Netsky[16] reviewed the literature in 1959 and found 59 cases reported up to that date. In 1962, Cooper and Von Hagen[3] added six more cases, and since then, five more cases have been reported, giving a total of 70 cases[2, 4, 6, 7, 11, 12, 14] with the most recent case being reported in 1966 by Manganiello, Daniel, and Hair.[9] Various associated brain anomalies have been reported, the most common of which is a complete absence of the corpus callosum. Some authors have felt that a midline lipoma is generally accompanied by agenesis of the corpus callosum. List, Holt, and Everett[8] pointed out that these lesions are not always coexistent. Approximately one half of the reported cases were associated with agenesis of the corpus callosum.

Case Report

This 58-year-old white man was admitted to Grant Hospital, Columbus, on November 5, 1966 because of blurred vision, falling episodes, and dizzy spells. These symptoms had been present for at least one month prior to his admission. He had difficulty in recalling events and was mentally confused.

Physical examination showed a regular pulse of 88 beats per minute, blood pressure 138/90 mm. Hg., and respiratory rate of 24. He was a very thin white male, disoriented, disagreeable, and uncooperative. Neurologically, he knew his age, the place, and the year and month. He did not cooperate with the sensory examination. No other neurologic abnormalities were found.

Routine laboratory work was normal. A brain scan on his fifth hospital day showed no localized lesions. A spinal tap was normal for both pressure, cell count, and chemistries. Skull films on November 10, 1966 showed curvalinear shaped calcifications in the frontal area with radiolucency enclosed within the parenthesis-shaped calcifications (Figs. 1A and 1B). A diagnosis of a lipoma of the corpus callosum was made radiologically. A left internal carotid angiogram (Figs. 2A and 2B) showed deviation of the anterior cerebral artery around the mass lesion. The arteriographic study further revealed an irregular dilated vessel, similar to that noted in one of the case studies reported.[9] On November 15, 1966, a pneumoencephalogram (Fig. 3) showed elevation of the third ventricle with separation of the lateral ventricles.

Throughout the patient's hospitalization, he showed varying degrees of confusion and disorientation. On the 16th of November at 9:10PM, he complained of being hot all over, although he had no fever. He showed varying degrees of cyanosis and progressive distress and at 9:30PM, was pronounced dead.

Autopsy revealed the secondary and tertiary branches of the pulmonary arteries to be filled with granular reddish-gray thrombi. These were more extensive in the right lung than the left. The brain weighed 1,550 grams and was grossly symmetrical. There was some widening of the gyri and narrowing of the sulci particularly over the frontal lobes. Over the anterior and superior surface of the anterior commissure of the cerebral hemispheres, there was a somewhat flattened, nodular mass measuring about 6 x 2½ x at least 5 cm., which had a yellow to orange-yellow color. Focal areas of calcification were present. This mass was soft and extended laterally into the brain substance on either side of the midline.

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Submitted November 17, 1969.

There was no corpus callosum, and only meninges and pia-arachnoid were present in the space covering the roof of the third ventricle. The mass intermediate was rather prominent.

The cut section of the brain showed soft yellow adipose tissue replacing the anterior two thirds of the corpus callosum with penetration of this adipose tissue into the adjacent cortical gray matter along the medial aspect of each of the frontal and parietal lobes and into the superficial portion of the subjacent white matter. There was linear calcification at the interface between the lipoma and the grey matter of the frontal and parietal lobes. There was mild to moderate dilatation of the lateral ventricle on the right side, particularly in the temporal horn of this ventricle. The choroid plexuses had their usual distribution and appeared adequate. The corpus callosum was totally absent posterior to the area of the lipoma, and here again, only meninges covered the roof of the third ventricle. There was total absence of the superior commissure of the brain. Coursing over the superior surface of the lipoma were one rather large artery and several smaller, although prominent, branches of the anterior cerebal arteries. No significant changes were found in the basal ganglia, thalamus, midbrain, pons-medulla, cerebellum, or spinal cord.

The autopsy revealed the immediate cause of death to be due to multiple pulmonary emboli. The patient had an unusual lesion, a lipoma of the corpus callosum associated with agenesis of the corpus callosum. How this was related to the patient's central nervous symptomatology during the interval before hospitalization is not clear except through possible lack of intercommunication between the two hemispheres.

Discussion

The origin of intracranial lipomas is controversial. According to Ewing,[5] they always arise from the pia. Cooper and Von Hagen[3] suggested that they are congenital or developmental lesions. There is no particular age or sex incidence. Lipomas of the brain have been observed in various locations, but they occur chiefly on the surface of the corpus callosum. Other locations have been in the base of the cerebrum, brain stem, cerebellum, roots of the cranial nerves, ventral aspect of the diencephalic structures, choroid plexus of the lateral ventricles, and the dorsal aspect of the midbrain. The histologic pattern is mainly mature adipose tissues with variable amounts of collagen. Infrequently they may contain muscle fibers and fibro-osseous tissue. Some lipomas have abundant vascularization.

The main symptoms associated with these lesions have been generalized convulsions and mental changes. Relatively few show paralysis or paresis, but hydrocephalus, headache, personality disorder, and obesity have been recorded. Many of the patients will exhibit no symptoms or signs.

Roukkula and Auttinen[12] have outlined the radiographic criteria for the diagnosis of lipomas of the corpus callosum as follows[1, 10, 13]: (1) midline lesion lying just above the corpus callosum; (2) radiolucent area at the site of the tumor, especially in the lateral view; and (3) symmetrical parenthesis-shaped calcifications in the posteroanterior projections.

Several lesions must be considered in the differential diagnosis. Gliomas of the corpus callosum may show calcification, but this calcification does





FIGS. 1A (left) and 1B (above). Towne's and lateral views show calcification about midline mass which has a lucent center.





FIGS. 2A (left) and 2B (above). Towne's and lateral views show deviation and stretching of anterior cerebral artery around the mass.

not have the dense linear character or the peripheral distribution seen with lipomas. Also, the radiolucent area is not present. A cavum septi pellucidi may be confused with agenesis of the corpus callosum, but this lesion is not likely to be confused with a lipoma of the corpus callosum, because the cysts do not contain calcium nor do they produce the radiolucent areas on the plain skull films.

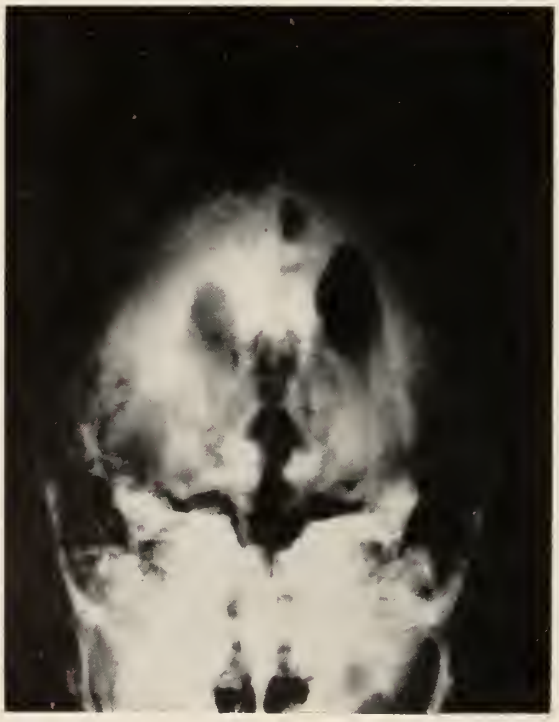


FIG. 3. Pneumoencephalogram showing separation of lateral ventricles with elevation of third ventricle.

Tumors of the septum pellucidum and ependymomas arising in the medial wall of the lateral ventricles may similarly separate the lateral ventricles. None of these lesions shows the typical peripheral calcifications or the zone of decreased density. A large calcified suprasellar cyst does not produce radiolucent areas on the plain skull films, and the pneumoencephalographic changes differ noticeably from those due to a lipoma. Craniopharyngiomas are in closer approximation to the sella turcica and often produce erosion of this structure.

It is generally agreed that excision of a lipoma of the corpus callosum is contraindicated.[7] Therefore, it is the responsibility of the radiologist and the neurosurgeon to diagnose this lesion without surgical exploration.

Summary

We have reported a case of a lipoma of the corpus callosum associated with agenesis of the corpus callosum verified at autopsy. This was diagnosed on the plain roentgenograms of the skull and further verified by arteriographic and pneumoencephalographic studies. In nearly all cases, a diagnosis can be established by the pathognomonic findings revealed in the plain skull films. Arteriograms and air studies are not essential

but may add considerable information concerning the presence or absence of the corpus callosum.

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Self-Evaluation Quiz

1. A 48-year-old carpenter complains of a stiff neck and pain in his right shoulder of insidious onset. His deep tendon reflexes are physiologic, and extending and laterally flexing his neck toward the right causes pain in his shoulder and his right thumb to tingle. What muscle group would you expect to find weak?
   (A) Triceps brachii
   (B) Intrinsic hand muscles
   (C) External shoulder rotators
   (D) Wrist extensors
   (E) Upper trapezius

[*From the Department of Physical Medicine, The Ohio State University College of Medicine. The answer is given on p. 497 of this issue.—Ed.*]

2. A child receives an intramuscular injection of tetracycline in the left buttocks and immediately complains of pain in the left leg, and the parent notes weakness of that leg. On physical examination, he probably will not be able to perform the following motion:
   (A) Walk on his left heel
   (B) Walk on his left toes
   (C) Squat and return to the standing position
   (D) Go up stairs
   (E) None of the above

[*From the Department of Physical Medicine, The Ohio State University College of Medicine. The answer is given on p. 497 of this issue.—Ed.*]

Ipecac-Induced Emesis for Acute Poison Ingestion

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IT HAS BEEN estimated that 500,000 accidental poisonings occur annually in the United States. Delay and incompleteness of emptying the stomach of these toxic substances, without question, adds to the morbidity and mortality of such cases. In a study done at Columbus Children's Hospital,[1] it was found that the mean time between ingestion and arrival at the emergency room was 68.7 minutes, 50 percent of the patients arriving after one hour.

Since the end of the nineteenth century and until the beginning of the last decade, the majority of these patients were treated with gastric lavage and suctioning. Then, in 1959, Arnold,[2] working on dogs, produced convincing evidence that the use of syrup of ipecac was more efficient in emptying the stomach than gastric lavage, and since that time the use of ipecac or other emetics has gained in popularity. Though much has been said in favor of ipecac, there still remain those who do not feel comfortable waiting for it to take effect, and after it has, many feel lavage is still necessary. The latest editions of two major pharmacology textbooks state that ipecac is either not useful at all in emergencies[3] or that two gastric lavages with 250 ml. of saline each are far better.[4]

An editorial in the *Journal of Pediatrics*[5] stated that clinical observation would indicate that emesis induced by ipecac syrup reclaims material beyond the pyloric sphincter of the stomach. When a measured amount of fluid was given with the syrup, from 84 percent to more than 100 percent of the volume was returned. Conversely, it was felt that gastric lavage may well wash poison from the stomach into the duodenum. Indeed, Arnold in studying the efficiency of lavage[2] found that recovered lavage fluid in 80 treated patients failed to contain significant amounts of ingested poison. To see if the poor return was influenced by rapid passage of the poison from the stomach to the intestine prior to lavage and passage into the intestines with lavage fluid, the pylorus of dogs was tied and under ideal conditions, five minutes after forced ingestion through a tube, only 50 to 60 percent of a given barbiturate could be recovered.

In another series,[6] to test whether lavage was necessary after ipecac-induced emesis, it was found that the ratio of ingested material returned by emesis to the amount returned with lavage following emesis was such as to suggest that lavage following ipecac-induced emesis was not necessary.

From data accumulated by Shirkey, it can be concluded that: (1) lavage carried out within 15 minutes is no more effective than emesis induced within 30 minutes of ingestion; (2) lavage carried out one hour after ingestion is inefficient

This student editorial was selected by Dr. Edward V. Turner, Professor of Pediatrics, The Ohio State University College of Medicine, from papers written by third year medical students studying pediatrics at Children's Hospital, Columbus, Ohio.
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and far less effective than emesis produced within the same time interval; (3) emesis (immediate or delayed as long as 1½ hour) appears to be more effective; and (4) neither lavage nor emesis under optimal conditions is consistent in effectiveness, so all patients, regardless of treatment, should be followed carefully.

Ipecac thus appears to be the treatment of choice over gastric lavage, as long as the patient is not unconscious, and has not ingested materials such as strychnine, a corrosive (acid or alkali), or a petroleum distillate.

When administered, ipecac should be of the syrup form (not the fluid extract) and given in a dose of 8 to 15 ml. This should be followed by at least 200 ml. of water or clear fluid. Vomiting is initiated by the drug's local action on the stomach and upper duodenum. The large amount of water or clear fluid is given to assure that the ipecac reaches the pylorus and duodenum quickly, since the cardiac end of the stomach is relatively insensitive to it.

Goodman and Gillman[3] state that 30 minutes to an hour or more is required for the onset of emesis, but clinically[1] it has been found that mean time for onset of emesis was 18.7 minutes, 88 percent of onsets occurring in less than 30 minutes. If no emesis occurs in 20 to 30 minutes a second dose can be given, or gagging or gastric lavage can be done. If no emesis occurs after the second dose, other means of emptying the stomach should be used, to avoid possible toxic effects of the ipecac.

To date there have been no reported cases of poisoning from 30 ml. or less of ipecac syrup, and all ipecac toxicities seem to have been from the erroneous use of the fluidextract, which is 14 times as concentrated as the syrup.

Since the largest part of the time interval between ingestion and onset of treatment is the time to get to the emergency room, this time could be greatly reduced if treatment were begun at home. A parent could call the family physician or poison control center to see if emesis is indicated, and if so, treatment could be started immediately. Since gagging and other home remedies to induce emesis have been found to have little consistency in effectiveness,[7] syrup of ipecac should be a necessity in every home with young children.

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Answers to Self-Evaluation Quiz

Page 495 Question 1. (C) This is a rather typical story of an individual who has cervical radiculopathy; the clue in the answer is that tingling of the thumb ordinarily identifies the root would be that at C6 and the appropriate muscles innervated by that root would be the external shoulder rotators.

Page 495 Question 2. (A) This is a sciatic nerve injection palsy and the most vulnerable portion of the sciatic nerve is the lateral division because it is superficial to the medial portion and it is relatively fixed as compared with the mobility of the medial portion. The lateral division of the sciatic nerve becomes the common peroneal nerve and innervates the foot dorsiflexors.

Etiology and Pathogenesis of Hypertension

Harriet P. Dustan, M.D.*

HYPERTENSION is a major cardiovascular problem that is largely unsolved. However, there is a variety of drugs available for treatment which used singly or in combination reduce arterial pressure substantially. Such therapeutic effectiveness tends to obscure the fact that we actually know very little about the mechanisms of hypertension and the functional details of its natural history.

Hypertension is a symptom, not a disease. We know it to be associated with a variety of diseases, but these affect only a small number of patients so that in most of them hypertension is without apparent cause. This condition is called essential hypertension. The term is an archaic misnomer because we now know that hypertension is not essential for anything. Long gone are the days when physicians believed elevated arterial pressure to be essential for maintenance of tissue perfusion.

Although elevated blood pressure, of itself, is a sympton, it is often associated with vascular diseases—arteriolar sclerosis or premature atherosclerosis. Arteriolar disease occurs more commonly in patients with severe diastolic hypertension, while premature atherosclerosis is usually a manifestation of long sustained arterial pressure elevation, even one of mild degree.

Hypertension can be classified in a number of ways according to: (1) the type of arterial pressure elevation—systolic, diastolic, or mixed, (2) the character of the elevation—labile or sustained, (3) severity of the associated vascular disease—mild, moderate, severe, or malignant (accelerated), (4) or etiology—renal, adrenal, cardiovascular, or essential. At our present level of knowledge, the etiologic classification is the most interesting. Not only does recognition of the various causes of elevated arterial pressure lead to more rational treatment, but also it gives an opportunity to study the mechanisms of hypertension.

The hypertensions that are associated with various diseases are called secondary. When none of these conditions is present, the hypertension is said to be primary. This term, like "essential," is a misnomer because each hypertension has a cause even though our knowledge is not sufficient to recognize it. Clearly, the more we have learned, the more we have seen; for example, consider the types of hypertension recognized in the past 20 years. These include primary aldosteronism, renal arterial disease, and increased activity of the beta-adrenergic component of the sympathetic nervous system. Before these types were recognized, such patients were considered to have "essential" or "primary" hypertension.

The physiologic abnormalities that have been found in hypertensives relate to the nervous control of the circulation, catecholamines, cardiac output and peripheral resistance, adrenal steroids, the renal pressor system, and plasma volume. Evidence is accumulating that these factors do not operate alone, and it seems likely that they make

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up an integrated system, one expression of which is elevated blood pressure.

When considering the etiology and pathogenesis of hypertension, it is an interesting exercise to see how these various factors are interrelated in the different types of hypertension. Of course, our present information is incomplete, but enough is available to make the exercise worthwhile.

The most frequently occurring secondary hypertensions now recognized are those associated with renal arterial disease and renal parenchymal disease, pheochromocytoma, primary aldosteronism, coarctation of the aorta, and increased activity of the beta-adrenergic nervous system.

In patients with *renal arterial disease,* the most likely cause of hypertension is, of course, the renin-angiotensin system. However, elevations of renin (which is the component most readily measured) are not routinely found. This suggests that other factors are also operating and since blood pressure can be lowered with drugs that suppress the activity of the sympathetic nervous system, this indicates a nervous component in the hypertension as well. In fact, we have recently shown that these patients often have exaggerated increases in blood pressure in response to head-up tilt. Further, they tend to have slightly increased cardiac output, which may represent an increase in nervous stimulation of the heart. Plasma volume can be decreased and, in our experience, it is inversely related to the plasma renin activity. Additionally, aldosterone production is often increased, producing a state of secondary aldosteronism. Thus, although we cannot put together all the pieces of information in an integrated fashion, evidence is accumulating that the hypertension accompanying renal arterial disease is an expression of a variety of abnormalities, only one of which is a disturbance of the renin-angiotensin system.

In *renal parenchymal disease,* there is not so much information available concerning the possible pressor factors. However, there have been studies in patients with chronic renal failure which show expansion of the extracellular fluid volumes and correction of hypertension when these excesses are corrected by dialysis. Further, there is a suggestion that with expanded plasma volume the nervous control of the circulation is lessened—possibly because it isn't so necesary when the blood volume is high. Plasma renin activity has not been consistently found to be elevated, although increased activity of the renin-angiotensin system seems likely in patients whose hypertension remits following bilateral nephrectomy done in preparation for transplantation. Thus, in this type of hypertension, there are indications that, in one way or another, three pressor factors participate—renal pressor, neurogenic, and fluid volume.

Pheochromocytoma seems a much more straightforward problem than that presented by the other two types of hypertension. Currently, we know that there is increased epinephrine and norepinephrine production, and this seems reason enough for the hypertension. Plasma volume can also be reduced, and this is important because it may explain the hypertensive crises that often occur in these patients following surgical removal of the tumor.

In *primary aldosteronism,* there is an increased production of aldosterone which can cause increases in body sodium, extracellular fluid volume, and plasma volume. Along with these increases, decreased activity of the sympathetic nervous system has been reported. Plasma renin activity is low suggesting that this is not a factor in the hypertension.

Increased activity of the beta-adrenergic component of the sympathetic nervous system can be associated with hypertension. These patients have palpitations and exaggerated tachycardia in response to a variety of normal stimuli, such as exercise. They have increased cardiac output but a normal or near normal peripheral resistance. Their hypertension can be controlled with beta-blocking drugs such as propranolol.

Coarctation of the aorta is also recognized as an occasional cause of hypertension. If patients are not in cardiac failure, apparently hemodynamic functions are normal, at least in the upper parts of the body above the coarctation. However, until flow beyond the coarctation can be measured reliably, hemodynamic characteristics of this type of hypertension cannot be determined. Other pressor mechanisms have not been studied in such patients.

Although most treatments of hypertension are empiric rather than based on specific pressor mechanisms, information is becoming increasingly available in various types of hypertension which bids well to describe a number of integrated circulatory disturbances, of which hypertension is one manifestation. These descriptions will provide rational, rather than empiric, treatment.

A MESSAGE FROM

Your OSMA President



AT THIS TIME LAST YEAR, I was anticipating my year in office as President of the Ohio State Medical Association. Now that my term is nearing its completion, there are a few thoughts I should like to share with my colleagues in Ohio.

As President of the Association, I have come into contact with a great many physicians — practitioners, medical educators, administrators, researchers, etc. In addition, I have exchanged ideas with many other persons in the medical and health care fields, students, community leaders, legislators, and many more.

I wish to take this opportunity to say "Thank you" to the many persons who are helping medical organization to achieve its purposes, which, as our Constitution states, are "to promote the science and art of medicine, and the protection of the public health." I particularly wish to thank those persons who helped me in my many activities as your President. It would be out of the question to pinpoint all of these fields of achievement, but there are several categories that perhaps are of special significance.

In behalf of the Association, and personally, I wish to thank:

• Members of The Council who were my closest associates during the year; members of the House of Delegates who represented their colleagues in the policy-making body; and our AMA delegates and alternate delegates who represent Ohio on the national level of organized medicine.

• Members of the various OSMA committees who help so ably in formulating Association policy.

• The hundreds of physicians working in the county medical societies, without whose support and encouragement the state organization could not function effectively.

• The hundreds of physicians on the local level who are doing liaison work with community groups and who are the medical profession's first line of public relations as well as public service.

• The many lay executives and members of their staffs who are working to put medical organization work in the forefront of our complex society. These devoted people carry a tremendous burden of work that otherwise would be borne by busy physicians.

• The Editor, the staff, and the many contributors to The Ohio State Medical Journal which has just entered a new phase as a line of communication for the medical profession of Ohio.

• Our friends in the U.S. Congress and in the Ohio General Assembly who have listened to medicine's voice and weighted our arguments; also to the many physicians who are keeping in touch with our legislators; members of the Ohio Medical Political Action Committee who are putting citizenship responsibility high on the priority rating.

• Leaders in the medical education field in Ohio who took time out of their busy schedules to meet with the Association's officers; also the many persons in key medical education positions throughout the state who are helping the Association to develop a central listing of continuing education opportunities in Ohio.

• The physicians and lay workers in our state agencies, voluntary health organizations, and ancillary services who are working with medicine for the public good.

• Officers and members of the Woman's Auxiliary for being by the side of medicine, and for their many worthy programs and projects.

• The members of my anesthesiology group in Toledo whose support and assistance largely made it possible for me to serve as your President —Drs. Katchka, Friedman, Crider, Kennedy, Ditmyer, Underhill, Brenner, Stevens, and Thrailkill.

It has been my privilege and honor to serve as your President. One lasting impression about my year in office is the dedication and devotion of many physicians who are doing their part to make medicine a meaningful part of our society. I am more sure than ever that organized medicine in this state does indeed reflect the thinking and purposes of the physicians of Ohio.

Robert N. Smith, M.D.

Robert N. Smith, M.D., President
The Ohio State Medical Association



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Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain and the United States have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives.

The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651:657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

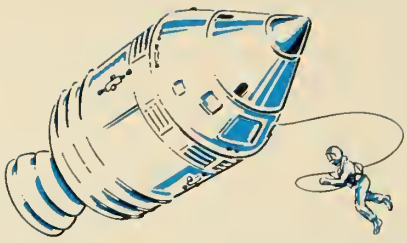


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Professional Activities

Proceedings of the Council

Meeting of February 21-22, 1970

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, February 21 and February 22, 1970, at the Crown Inns Motor Lodge, 888 East Dublin-Granville Road, Columbus.

All members of the Council were present on Saturday, February 21. Others attending the meeting were: Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. James S. Imboden, Columbus, AMA Field Representative; Dr. Ben Arnoff, Columbus, chairman of the Professional Relations Committee, Columbus Academy of Medicine; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Price and Moore of the OSMA headquarters office staff.

Those present on Sunday, February 22, were: All members of the Council; Mr. Imboden; Dr. Anthony Ruppersberg, Columbus, chairman of the OSMA Committee on Maternal Health; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Price, and Moore of the headquarters office staff.

President's Press Conference

President Smith discussed the February 12 press conference dealing with the staff report of the U.S. Senate Finance Committee on Medicare and Medicaid. It was indicated that the general coverage was good throughout the state and that several errors were contained in the Associated Press story, and that the Associated Press advised that it had sent out corrections.

Minutes Approved

Minutes of the meeting held December 13-14, 1969, **were approved** by official action.

Reports by Councilors

The Councilors reported on organizational activities in their respective districts.

Belmont County Situation

With regard to a situation arising in Belmont County, involving a question of parliamentary procedure in the conduct of a county medical society meeting, it was the consensus of the Council that parliamentary procedure matters should be settled at the county society level and that it is not the desire of the Council to interfere with the internal workings of a county society.

Amendments to Bylaws

Clermont County

Amendments to the Clermont County Medical Society bylaws **were approved.**

Lucas County

Final **approval** of amendments to the bylaws of the Toledo Academy of Medicine was granted by the Council.

Amendments to Bylaws of Women's Auxiliary

The Council voted that amendments to the bylaws of the Woman's Auxiliary to the Ohio

State Medical Association be held in abeyance and not acted upon this year.

Meeting with Officials of Medical Schools

A meeting with the medical school officials was held on Saturday afternoon, February 21, as a special order of business. The following officials of the medical schools located in Ohio were present: Dr. Glidden L. Brooks, president, Dr. Robert G. Page, dean, and Dr. M. A. Ayers, professor, the Medical College of Ohio at Toledo; Dr. F. C. Robbins, dean and Dr. Daniel L. Horrigan, professor, Case Western Reserve University School of Medicine; Dr. Clifford G. Grulee, Jr., dean, and Dr. William A. Altemeier, professor, University of Cincinnati College of Medicine; Dr. W. G. Pace, professor of surgery, representing the Ohio State University College of Medicine.

The discussion involved relationships with the medical schools and the Ohio State Medical Association and the relationship of the two organizations with medical school students, interns and residents.

Increases in student enrollment for entering classes during the next several years were announced by all schools, with indications that enrollments will be increasing at Toledo from 32 to 96; Cincinnati from 110 to 192; Ohio State University from 175 to 264; and Case Western Reserve University School of Medicine from 88 to 150.

Discussion of mutual problems continued throughout the afternoon.

1970 Annual Meeting

Mr. Campbell presented a progress report on the 1970 Annual Meeting, to be held in Columbus, May 11-15.

American Medical Association

Long-Range Planning

The Council received a report from Dr. Richard L. Meiling, Columbus, on the report of the ad hoc Committee on Long-Range Planning and Development of the House of Delegates of the American Medical Association. Dr. Meiling indicated that the report of the committee will propose a long-range program and development committee. The charge will be as follows:

"A. To study and make recommendations concerning the long range objectives of the Association.

"B. Study and make recommendations concerning the projected resources, programs, and organizational structure by which the Association attempts to reach its long-range objectives.

"C. Serve as a focal point for the planning activities of the Association and stimulate planning activities throughout the organization.

"D. Study or consider to be studied, Medicine, and the future environment in which the Association must function, collect relevant data, and transmit its interpretation of these studies and data to the Board of Trustees, to decision-making centers throughout the United States, and submit an appropriate annual report to the Board of Trustees through the House of Delegates."

The Council voted to submit to the AMA House of Delegates in June a resolution endorsing and supporting the above recommendations.

Budd Campaign

It was announced that all AMA delegates and state medical societies had been notified that Dr. John H. Budd, Cleveland, is the candidate of the Ohio State Medical Association for a seat on the AMA Board of Trustees, presently held by Dr. Irvin Hendryson, New Mexico, who will be a candidate for president-elect.

Clinical Meeting in Cincinnati

The Council **approved** the request of the Cincinnati Academy of Medicine, asking endorsement of the invitation from the Cincinnati Academy to the American Medical Association to hold the 1975 or 1976 clinical meeting of the AMA in Cincinnati.

Ohio Medical Indemnity, Inc.

Dr. Light, as chairman, presented a report of the nominating committee appointed by the President to submit the names of candidates for the Board of Directors of Ohio Medical Indemnity, Inc. The committee recommended that the following be nominated and elected for the ensuing year: Ralph L. Abernathy; Dwight L. Becker, M.D.; William T. Blair; Guerney H. Cole, Jr.; William R. Culbertson, Jr., M.D.; Donald W. De Wald, M.D.; Clair E. Fultz; Paul A. Jones, M.D.; Robert E. Howard, M.D.; William B. McKelvey; Robert A. McLemore, M.D.; John R. Meek, M.D.; Usher B. Redmann; Theodore T. Reed, Jr.; James G. Roberts, M.D.; William J. Schrimpf, M.D.; Frank L. Shively, Jr., M.D.; M. M. Thompson, Jr., M.D.; Gordon M. Todd, M.D.; William A. White, Jr., M.D.

By official action, The Council **approved** the nominations presented and authorized the following to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stock-

holders' meeting of OMI in April on all business matters coming before that meeting, including the election of directors placed in nomination by the Council at this meeting on February 21-22, 1970: Dr. Theodore L. Light, Dayton, or Dr. Dwight L. Becker, Lima, or Mr. Hart F. Page, Columbus.

On behalf of the Council, the president was authorized to thank the retiring directors for their past services.

Usual and Customary Fee

Dr. Ben Arnoff, Columbus, Chairman of the Professional Relations Committee of the Academy of Medicine of Columbus and Franklin County, appeared before the Council with regard to his request for clarification of the discussion of usual and customary fee, by the Council of the Ohio State Medical Association at the October 4-5, 1969, meeting in connection with the Ohio Medical Indemnity usual, customary and reasonable charge program.

Council voted to amend its action of October 4-5, 1969, by changing paragraph two of Section one of the report to read as follows:

> "In determining what constitutes a usual, customary and reasonable charge it is recommended that Ohio Medical Indemnity, Inc. take into consideration: unusual medical circumstances or complications requiring additional time, skill or experience in connection with a particular case; the charge most frequently made for a given service by the individual physician who rendered a particular service; the usual charges of physicians generally of similar training and experience in that particular area for the same or similar services; and all other pertinent information which may have a bearing on the physician's charge."

In connection with the communication from Dr. Arnoff involving the fee review procedure in connection with OMI cases, the Council voted to request of Ohio Medical Indemnity that before cases are sent to the county medical societies via the Ohio State Medical Association and the district councilor that such cases first be reviewed by the Ohio Medical Indemnity medical director.

Fee Review

The Council approved, in principle, the development of the Ohio State Medical Association fee review procedure for the use of the Council and the Council's fee review committee.

Richland County Case

A complaint concerning a case reviewed by the Richland County Medical Society was referred to the OSMA Council's Fee Review Committee for study.

Committee Reports

Cancer

Minutes of the February 12 meeting of the Ohio Cancer Coordinating Committee, Inc. were presented by Mr. Clinger.

The Council **approved** the minutes which included the following recommendations:

> (1) "Approval, in principle, of a study of the entire spectrum of cancer control on a statewide basis. Such a study would include health education, health protection, the asymptomatic person, diagnosis, therapy, rehabilitation, extended care and custodial care —as a basis for establishing health goals to improve the care of the cancer patient in the State of Ohio.
>
> (2) "That the sum of $50,000 be requested from the Ohio State Regional Medical Program in order to plan and develop the study."

Education

Mr. Edgar presented the minutes of a meeting of the Commission on Medical Education held February 4, 1970. The minutes were accepted for information.

Hospital Relations

Mr. Gillen presented minutes of the February 18 meeting of the Committee on Hospital Relations. The Council **approved** the minutes, which included the following recommendations:

Hospital Licensure Bill — Approval of the minutes included approval of the committee's recommendation that the definition of hospital services under a proposed hospital licensure bill be as follows:

> "That this definition be incorporated in the bill and designated as definition 'G'. 'Hospital services' are those provided by administration of the hospital excluding services of licensed physicians. Such professional medical care is the responsibility of the physicians of the organized medical staff of the hospital."

With regard to the same measure, the Council **approved** the recommendation of the committee that the Ohio Public Health Council be consituted as the licensing authority.

Military Medical Corpsmen in Hospitals — Council **approved** the committee's endorsement of a program involving utilization of the services of

former military medical corpsmen in hospitals and voted to cooperate with the Ohio Hospital Association in this matter.

Physicians on Hospital Governing Boards — The Council **approved** the following statement developed jointly by the Ohio Hospital Association and the Ohio State Medical Association with regard to physicians on hospital governing boards:

> "Those persons elected or appointed to hospital governing boards should be individuals qualified to apply the principles of good trusteeship and reflect a broad representation of the community rather than representation of special interests within or outside the hospital.
>
> "No person should be denied governing board membership because of occupation, and hospital bylaws should endorse this principle.
>
> "Physicians, as representatives of the community, should be eligible for membership on hospital governing boards in the same manner as are all other knowledgeable and effective individuals."

Maternal Health

Minutes of the meeting of the Committee on Maternal Health held January 17-18, 1970, and the Ohio Maternal Mortality Study-1966 Annual Report, were presented by Dr. Ruppersberg and by Mr. Gillen.

The Council congratulated Dr. Ruppersberg and **approved** the minutes and the report.

Medicine and Religion

The minutes of a meeting of the Committee on Medicine and Religion held February 18, 1970, were presented by Mr. Campbell and were accepted for information.

Private Practice

Minutes of the January 21 meeting of the Committee on Private Practice were presented by Dr. Lieber. Council **approved** the minutes, including a redrafted definition of private practice which now reads as follows:

Definition of Private Practice

> "Private practice is that system of medical care whereby there is full freedom of choice for the patient in selecting his physician, or group of physicians, and, except in cases of emergency, there is full freedom of choice for the physician, or group of physicians, in accepting his patient. Under such system, the individual patient is responsible to the individual physician, or group of physicians for reimbursement for such medical care."

The Council also **approved** a set of priorities developed for the operation of the committee.

Public Relations

Mr. Edgar reported on the January 8 postal card poll of the Committee on Public Relations, amending the October 22, 1969, minutes of the Committee on Public Relations. The amended minutes **were approved** by the Council.

School Health

The minutes of the February 8 meeting of the Rubella Immunization Subcommittee were presented by Mr. Clinger. The recommendations of the subcommittee were subsequently approved by mail by members of the Committee on School Health. As **approved** by the Council, the recommendations are as follows:

> "That a meeting be called of the Committee on School Health, together with representatives of the Ohio Academy of General Practice and the Ohio Chapter, American Academy of Pediatrics—and that authorities on rubella immunization be invited to share their views.
>
> "Further, that the meeting be held as soon as possible because of the impending rubella epidemic — and that recommendations on mass immunization emanating from the meeting be considered joint recommendations of the OSMA Committee on School Health, Ohio Academy of General Practice, and Ohio Chapter, American Academy of Pediatrics."

OSMA Opinion Survey

Mr. Gillen reported on the OSMA opinion survey. He indicated that 9,975 survey forms were mailed to members and that 5,300 members responded to the survey by the cutoff date for returns of February 13, 1970. He indicated that the replies were being programmed into the computers.

Peer Review

Dr. Henry discussed peer review and presented to the Council preliminary materials with regard to a suggested educational program on this subject. He also presented a proposed survey for the purpose of seeking information as to the scope and quality of review now being accomplished. The survey **was approved** in general by the Council.

Auditing and Appropriations Committee

The Council adjourned and reconvened in executive session for a special report on legal services by the Committee on Auditing and Appropriations. The executive session then adjourned and the Council reconvened in regular session.

Student AMA

The Council voted to encourage the development and continuation of Student American Medical Association chapters and authorized the Auditing and Appropriations Committee to explore the development of a fund which might be used for specific projects involving the student AMA on an individual basis.

The Council **approved** the suggestion of the Committee on Auditing and Appropriations that $15 be contributed by the Woman's Auxiliary to the Student American Medical Association and the matter of the financial report for this organization be referred by Dr. Clarke to the Woman's Auxiliary of the Ohio State Medical Association.

It was the consensus of the Council that the county medical societies should involve student AMA chapters in their activities wherein it is practical to do so.

Congress of Parents and Teachers

In answer to a communication from the Ohio Congress of Parents and Teachers, the Council expressed its appreciation and indicated that the Association would be pleased to work with the Congress of Parents and Teachers on health matters.

Osteopaths in Medical Groups

In answer to a communication from a member with regard to whether a group of medical doctors should accept doctors of osteopathic medicine and surgery into such groups, Council expressed an opinion that there is no objection to such acceptance, providing such osteopathic physicians and surgeons meet standards of the ethical practice as outlined in the ruling on accepting osteopathic physicians and surgeons on general hospital staffs as adopted by the Council of the Ohio State Medical Association on December 16-17, 1961. The statement reads as follows:

> "1. The doctor of osteopathy must have qualified to practice osteopathic medicine and surgery under the Ohio Medical Practice Act as amended in 1943 which confers on him unrestricted rights and legal recognition in Ohio as a physician.
>
> "2. He must practice a method of healing founded on the principles of scientific medicine.
>
> "3. He must in good faith endeavor to conform to ethical principles equivalent to the Principles of Medical Ethics of the AMA.
>
> "4. His professional and scientific competence must be such that he can give his patients scientific medical care and make contributions to programs to maintain and improve the health of the community.
>
> "In the opinion of the Council of the Ohio State Medical Association voluntary professional association between a doctor of medicine and a doctor of osteopathy who meets all the foregoing basic standards would not be deemed unethical."

Senate Finance Committee Reports

Mrs. Charles Price, Director of the Department of Economic Research, presented and discussed his written analysis of the Senate Finance Committee's Staff Report on Medicare and Medicaid.

Comprehensive Health Planning

In answer to a request from the Columbus Academy of Medicine, the Council voted to support and assist the Columbus Academy of Medicine to obtain approval of the Academy's health services proposal involved in the comprehensive health planning program.

Manpower Program

The Council voted to **approve,** in principle, the joint sponsorship with the Medical College of Ohio at Toledo a pilot manpower program involving the utilization of military corpsmen in the physician's office.

Ohio Committee for Voluntary Health Planning

Dr. Schultz, chairman of the Ohio Committee for Voluntary Health Planning, sponsored by the Ohio State Medical Association, Ohio Hospital Association and Ohio Osteopathic Association of Physicians and Surgeons, submitted a proposed policy statement on the purposes of this committee. The statement was **approved** as follows:

> "The purpose of this committee is to advocate voluntary health planning. This purpose will be achieved by:
>
> A. Serving as a forum for expression of common concerns, discussion of problems, identification and exploration of alternative solutions;
>
> B. Supporting the concepts of health program development through local community involvement;
>
> C. Encouraging development and evaluation of new concepts in health programs;
>
> D. Urging the initiation and support of

legislative efforts to maintain and/or enhance voluntary health planning;

E. Reviewing and commenting on administrative information, policy and/or regulatory statements promulgated in reference to, or having a bearing on, health planning;

F. Providing information, education, advice and recommendations to the governing bodies of the sponsoring organizations, participating agencies and to other agencies, and/or groups at local, state and national levels."

State Legislation

Mr. Page reviewed the following bills which have been introduced in the Ohio Legislature and Council's actions were as indicated:

H.B. 292, Mussey, to eliminate the requirement that commissioners of general health districts be physicians. (Reaffirmed opposition, unless qualifications meeting the approval of the Ohio State Medical Association are specified in the bill.)

H.B. 852, Cruze, to prescribe forms for use in connection with the Uniform Anatomical Gift Act. (Support.)

H.B. 872, Batchelder, compulsory arbitration proceedings for malpractice cases. (Opposed in present form.)

H.B. 874, Mastics et al., omnibus drug control bill. (Opposed to section requiring physicians to report to the police, if they are called upon to treat a person addicted to an illegal drug.)

H.B. 919, Bechtold, to provide for the licensing of clinical laboratory personnel. (Opposed.)

H.B. 929, Swanbeck, et al., to create a rehabilitation services commission. (Approved.)

H.B. 990, Hollington et al, to require that drugs dispensed on prescription be named on the label unless excepted by the practitioner. (Opposed.)

H.B. 1025, Sweeney, to provide for the treatment of drug addicts and users. (Needs further study.)

H.B. 1042, Fraser et al., to authorize professional corporation to purchase shares it has issued. (Approved.)

H.B. 1049, Netzley, to require the graduates of Ohio supported medical schools to practice general medicine in Ohio for at least two years or reimburse the state for the amount of money it costs the state for his education over and above that covered by tuition . . . currently, $4,950.00 (Opposed in present form.)

H.B. 1051, Hill, et al., to place exempt narcotics and hypodermic syringes upon prescription. (Opposed—would not solve the problem.)

H.B. 1052, Mastics et al., pretrial procedure involving physicians. (No position.)

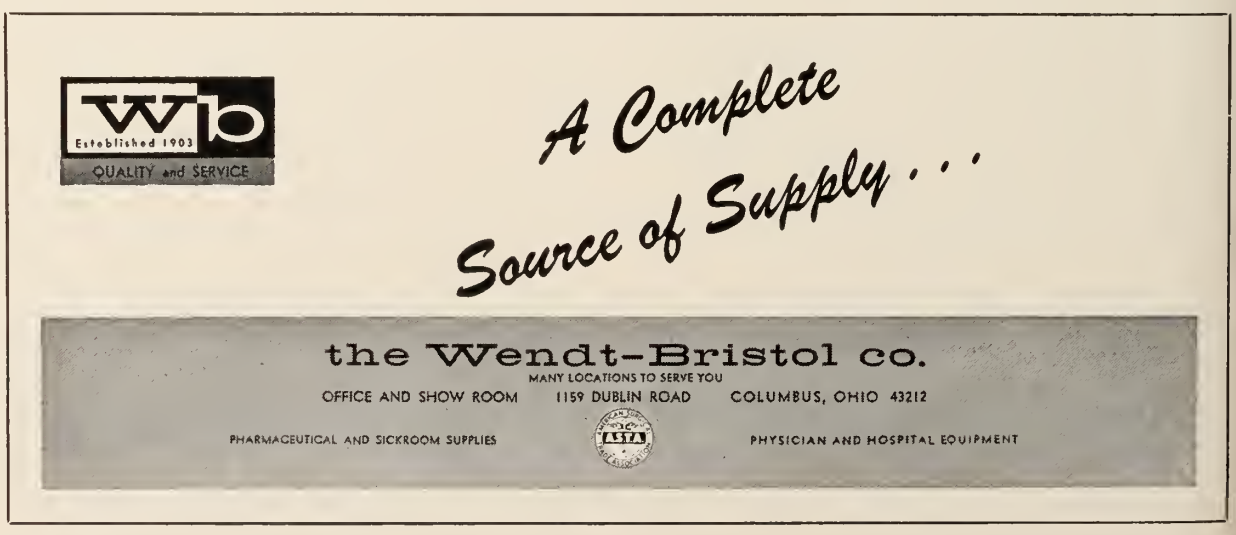
S.B. 455, Bowen, to allow 18-year-olds to give consent as blood donors. (No position.)

S.B. 497, Weisenborn, relative to nutritive and nonnutritive sweeteners in soft drinks. (Needs further study.)

The Council voted to sponsor, on behalf of the Ohio State Medical Board, a bill to change citizenship requirements and revise various fees charged by the Board in connection with its activities.

There being no further business, the Council adjourned, setting April 18 and April 19 as the dates for the next meeting.

ATTEST: Hart F. Page,
Executive Secretary



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WEDNESDAY, MAY 20

The Marijuana Problem—**Victor M. Victoroff, M.D.** attending physician, Huron Road Hospital; President, Ohio Psychiatric Association Education and Research Foundation. Jim Badger, Student

The Psychology of Anti-War Protest and Dissent—**Cyrus Wolfman, M.D.** Department of Psychiatry, Brookdale Hospital Center, Brooklyn, N. Y.

The Relation of Social Taboos to the Generation Gap and Emotional Problems: Obscenity, Profanity, Dirt, Nonsense and Nudity—**Irving M. Rosen, M.D.** Director, Community Services, Cleveland State Hospital; Senior Clinical Instructor in Psychiatry, Case Western Reserve University, Cleveland

Human Sexuality and the Problems it May Raise for the Physician—**Natalie Shainess, M.D.** Psychoanalyst: Lecturer, Columbia University College of Physicians and Surgeons and William Alanson White Psychoanalytic Institute, New York, N. Y.

Avoidable and Non-Avoidable Complications Occurring with Drugs used in Treatment of Emotional Disorders—**T. George Bidder, M.D.** Associate Professor of Pharmacology in Psychiatry; Assistant Professor of Medicine; Senior Clinical Instructor in Anesthesiology, Case Western Reserve University, Cleveland

The Fatally Abused Child: Lethal Brutality in the Home—**Lester Adelson, M.D.** Pathologist and Chief Deputy Coroner, Cuyahoga County; Professor of Forensic Pathology, Case Western Reserve University, Cleveland

What are Computers Doing in Medicine?—**Robert L. Williams** Staff Consultant in Medical Systems, Control Data Corporation, Minneapolis, Minnesota

Current Trends in Medical Education—**Frederick C. Robbins, M.D.** Dean, Case Western Reserve University School of Medicine, Cleveland, Ohio; Professor of Pediatrics, Case Western Reserve University, Cleveland

The Role of Government in the Delivery of Psychiatric Services—A Model for Health Care?—**Alvin M. Mesnikoff, M.D.** Professor of Psychiatry, State University of New York, Downstate Medical Center, Brooklyn, New York; Director, South Beach Psychiatric Center, Brooklyn, N. Y.

Recent Trends in Personal Injury Law—**Robert J. Joling, J.D.** Attorney, Baker, Juliani, Stanhope, Joling and Greco, Kenosha, Wisconsin; Executive Committee, American Academy of Forensic Sciences

Recent Trends in Malpractice Law—**Cyril H. Wecht, M.D., J.D.** Director, The Pittsburgh Institute of Legal Medicine; Coroner, Allegheny County, Pennsylvania; Director, Institute of Forensic Sciences, and Research Professor of Law, Duquesne University School of Law; Director, Pittsburgh Pathology and Toxicology Laboratory; President, American College of Legal Medicine

THURSDAY, MAY 21

Commonly Missed Vascular Problems—**James A. DeWeese, M.D.** Professor of Surgery, University of Rochester School of Medicine and Dentistry, Rochester, N. Y.

Commonly Missed Neurologic Problems—**Simon Horenstein, M.D.** Professor of Neurology, St. Louis University School of Medicine, St. Louis, Missouri

Psychiatric Problems in Surgical Practice—**Douglas A. Goldman, M.D.** Director, Department of Psychiatry, Good Samaritan Hospital; Assistant Clinical Professor of Psychiatry, University of Cincinnati College of Medicine, Cincinnati

The Current Abortion Scene—**Richard A. Schwartz, M.D.** Clinical Director, Fairhill Mental Health Center, Cleveland; Clinical Instructor in Psychiatry, Case Western Reserve University; Chairman, Association for Reform of Ohio Abortion Law, Cleveland

Medical Aspects of Pollution—**Jerome I. Kleinerman, M.D.** Head, Department of Pathology Research, St. Luke's Hospital, Cleveland

Changing Concepts of Aging—**Eric A. Pfeiffer, M.D.** Associate Professor of Psychiatry and Director, Joint Medical Legal Education Program, Duke University Medical Center, Durham, N. C.; Lecturer, Law and Psychiatry, Duke University School of Law, Durham, N. C.

Current Status of "THE PILL"—**Kenneth J. Ryan, M.D.** Professor of Obstetrics and Gynecology, Case Western Reserve University, Cleveland

A Panel on Homicide and Violence

A. Homicide Prevention and American Medicine—**Emanuel Tanay, M.D.** Senior attending Psychiatrist, Detroit General Hospital; Adjunct Associate Professor of Psychiatry, Wayne State University; Lecturer, Wayne State University Law School, Detroit

B. Guns, Homicide, Suicide and Accidents—**Bruce L. Danto, M.D.** Assistant Professor of Psychiatry, Wayne State University; Director, Suicide Prevention Center, Detroit Psychiatric Institute; Director, Community Psychiatry, Herman Kiefer Hospital, Detroit

Some Aspects of Human Power Struggles—**Gerald J. Sarwer-Foner, M.D.** Associate Professor of Psychiatry, McGill University School of Medicine; Director of Psychiatry, The Queen Elizabeth Hospital of Montreal; Training Analyst, Canadian Institute of Psychoanalysis, Montreal, Canada; Visiting Professor of Psychiatry, Laval University School of Medicine, Quebec, Canada

Hidden Hostility—Helper's Hindrance—**Herbert M. Perr, M.D.** Psychoanalyst, Rockville Centre, New York; Medical Director, Mental Health Clinic, South Nassau Community Hospital, Oceanside, N. Y.

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OSMA Opinion Survey

How Members Responded to Questionnaire

THE 1970 OSMA MEMBERSHIP Opinion Survey is history in regard to collecting and tabulating returns. The task of analyzing the data now is before officers and committees of the association.

There were 9,975 questionnaire forms mailed to OSMA members. The returns totaled over 5,400 for a 55 percent response. Approximately 650 of the survey forms returned were not processed in the final tabulation because they were either received too late or were not sufficiently completed.

Over 2,300 members responded to questions 18 and 19 of the survey asking for comments in regard to the Ohio State Medical Association and the American Medical Association. A transcript of these responses amounted to over 300 pages of typed comments.

Future issues of the *Ohio State Medical Journal* will carry summarizations of the comments about OSMA and AMA. Comments made in regard to the AMA will be forwarded to the appropriate officers of that organization.

A detailed tabulation of the returns by county, type of practice, location of practice and age group for questions 1 through 17, comprising several hundred pages, is available in the OSMA headquarters offices.

A detailed report on each county is available for county medical societies wishing to know how their members responded to various questions. This report would also include written comments on questions 18 and 19. County society officers wishing this information should contact their District Councilor or write directly to the OSMA office.

The OSMA Committee on Membership and Planning has the specific responsibility for reviewing and studying the results of the survey. This committee is chaired by Dr. William R. Schultz, Wooster, and has other members as follows: Dr. John H. Budd, Cleveland; Dr. Dwight L. Becker, Lima; and Dr. William M. Wells, Newark.

Printed in the following columns is a gross summary of the responses to questions 1 through 17.

SUMMARY OSMA OPINION SURVEY

1. Which of the following do you utilize in your continuing medical education? (Circle all that apply)

	Total	Yes	%	No	%
a. Educational radio-television	2675	1188	44	1487	56
b. Audio tapes	2886	1581	55	1305	45
c. Formal courses and lectures	3776	3438	91	338	9
d. County, state and AMA meetings	3613	2873	80	740	20
e. Specialty Society and AAGP meetings	3896	3611	86	285	14
f. Hospital staff meetings	4208	3972	94	236	6
g. Medical literature	4568	4518	98	50	2
h. Contacts with professional colleagues	4090	3963	97	127	3
i. Other	1478	819	55	659	45

2. Do you feel the Ohio State Medical Association's present activities in continuing medical education should: (circle only one)

a. Be increased	A	2012	45%
b. Be decreased	B	279	6%
c. Remain the same	C	2186	49%
		4477	100%

OPINION SURVEY — Continued

3. Would you favor participation in a continuing medical education program as a requirement for:

	Total	Yes	%	No	%
a. Membership in county and state medical societies?	4147	1543	37	2604	63
b. Membership in specialty society or AAGP?	4249	2525	59	1724	41
c. Reappointment to hospital staff?	4114	1754	43	2360	57
d. Maintenance of license?	4148	1452	35	2696	65

4. Does the scientific portion of the Ohio State Medical Association Annual Meeting provide an important means of your continuing education?

Total	Yes	%	No	%
4585	1373	30	3212	70

5. In the past three years have you attended any of the following types of medical meetings?

	Total	Yes	%	No	%
a. OSMA Annual Meeting	4086	2063	50	2023	50
b. American Medical Association	3710	962	26	2748	74
c. Specialty Society or AAGP	4475	3914	87	561	13
d. Voluntary Health Agency	3425	1220	36	2205	64
e. Government sponsored	3323	682	21	2641	79

6. What value do you place on exhibits at the OSMA Annual Meeting as a source of information on drugs, appliances, etc.? (Circle only one)

a. Valuable	A	959	21%
b. Some value	B	1807	40
c. Little or no value	C	639	14
d. No opinion	D	1154	25
		4559	100%

7. Rate the following as to their significance in keeping abreast of OSMA policies and activities: (Circle appropriate letter in each category)

	Total	Very Important		Moderately Important		Not Important	
a. OSMAgram	4492	2391	53%	1751	39%	350	8%
b. Ohio State Medical Journal	4484	1289	29	2488	55	707	16
c. Special Newsletters	4143	1877	45	1749	42	517	13
d. District Councilors	3883	272	7	1066	27	2545	66
e. Local Medical Society Meetings	4306	1123	26	1816	42	1367	32

8. Do you feel the OSMA has done a satisfactory job in keeping you informed on the following?

	Total	Yes	%	No	%
a. Legislative matters	4544	4138	91	406	9
b. Scientific advances	4283	2151	50	2132	50
c. Medical socio-economic matters	4319	3034	70	1285	30
d. OSMA policies and activities	4428	3907	88	521	12

9. Do you favor the employment of trained "physician's assistant" to work in physicians' offices performing such tasks as:

	Total	Yes	%	No	%
a. Preliminary screening for illness	4409	2040	46	2369	54
b. Well-baby examinations	4154	1638	39	2516	61
c. Family planning	4184	1974	47	2210	53

(Continued on Next Page)

OPINION SURVEY — Continued

10. Have you in the past 12 months contacted a legislator on a specific issue involving medicine and public health?

Total	Yes	%	No	%
4747	1640	35	3107	65

11. Do you feel the OSMA should give consideration to developing a form of membership for medical students?

Total	Yes	%	No	%
4590	2906	63	1684	37

12. The American Medical Association has changed its bylaws so that qualified Doctors of Osteopathy may be admitted to full active membership in the AMA with the constituent associations and component county societies being the judge of those so qualified. Do you agree with this action?

Total	Yes	%	No	%
4636	3332	72	1304	28

13. How would you rate the following as public health problems in Ohio today?

	Total	Very Pressing		Moderately Pressing		Not Pressing	
a. Air pollution	4720	3713	79%	893	19%	114	2%
b. Water pollution	4715	4011	85	642	14	62	1
c. Alcoholism	4649	1894	41	2266	49	489	10
d. Drug abuse	4672	2910	62	1539	33	223	5
e. Infant mortality	4493	614	14	1914	43	1965	43
f. Malnutrition	4518	386	9	1505	33	2627	58
g. Mental health	4613	1727	37	2287	50	599	13

14. Do you feel that the medical profession has done a satisfactory job of enforcing its self-imposed ethics?

Total	Yes	%	No	%
4618	2642	57	1976	43

15. Would you be willing to serve on the following committees?

	Total	Yes	%	No	%
a. Professional Ethics	4329	2615	60	1714	40
b. Fee Review	4277	2288	53	1989	47
c. Utilization Review	4229	1908	45	2321	55

16. Estimate the number of hours you work per week, including professional reading, paper work, preparation of scientific papers, office management and committee meetings.

a. Under 50 hours	625	13%
b. 50-60 hours	1471	32
c. 60-70 hours	1611	35
d. Over 70 hours	943	20
	4650	100

17. Do you "direct bill":

	Total	Yes	%	No	%
a. Welfare and Medicaid patients?	3892	1926	49	1966	51
b. Medicare patients?	3996	3255	81	741	19
c. Private patients?	4166	4042	97	124	3
d. Non Applicable?	454				

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Contraindications. History of sensitivity to meprobamate.

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction, occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

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WEDNESDAY, MAY 13, 1970
2:00 P.M., Main Auditorium
Veterans Memorial Building

Roger O. Egeberg, M.D.

Washington, D.C.
Assistant Secretary for Health and Scientific Affairs
Department of Health, Education, and Welfare





TUESDAY, MAY 12, 1970
1:30 P.M., Main Auditorium
Veterans Memorial Building
"A Fictional Doctor Reveals What His Non-Fictional Patients Think About the Medical Profession"
NICHOLAS P. DALLIS, M.D.
Scottsdale, Arizona

degree, Temple University School of ine. Practiced psychiatry in Toledo, for 15 years. Discontinued practice in to devote full-time to authorship of 3 strips, Rex Morgan, Judge Parker and ment 3-G.





THURSDAY, MAY 14, 1970
2:00 P.M., Main Auditorium
Veterans Memorial Building
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The Programs are in conjunction with the Ohio State Medical Association Annual Meeting, May 11-15, 1970

1970 OSMA ANNUAL MEETING HIGHLIGHTS

Sheraton-Columbus Hotel
(Headquarters Hotel)

Scientific Sessions and Exhibit Hall
Veterans Memorial Building

May 11, 12, 13, 14, and 15

MONDAY, MAY 11

4:00 P.M.	Councilor District Caucus Meetings
5:30 P.M.	Buffet Dinner for Delegates, Alternates, OSMA Council and Official Guests
7:00 P.M.	First Session—Business Meeting OSMA House of Delegates

TUESDAY, MAY 12

8:30 A.M.	General and Pre-registration
9:00 A.M.	Resolutions Committees Meet
9:00 A.M.	Athletic Injury Conference "The Health Team—For Better Athletics, Better Living"
9:30 A.M.	Section and Ohio Society of Pathologists
11:00 A.M.	Health Commissioners Institute Meeting with Director of Health
12:00 Noon	All Exhibits Open (Technical, Scientific and Health Education)
12:00 Noon	Orientation Session of new OSMA Members, "complimentary luncheon"
1:30 P.M.	Continuation of Reference Committee Meetings, if necessary
1:30 P.M.	OSMA General Session Speaker: Nick Dallis, M.D. "A Fictional Doctor Reveals What His Non-Fictional Patients Think About the Medical Profession"
2:00 P.M.	Section and Ohio Society of Pathologists
2:30 P.M.	School Health Conference "Growing Up With Sex Education"
3:00 P.M.	Health Commissioners Institute
Evening	Ohio Division, Inc. American Cancer Society (Cocktails and Dinner)
6:00 P.M.	Health Commissioners Banquet

TUESDAY (Continued)

6:00 P.M.	Ear, Nose and Throat Section and Ohio Ear, Nose and Throat Society Reception

WEDNESDAY, MAY 13

8:30 A.M.	General and Pre-registration
9:00 A.M.	All Exhibits Open
9:00 A.M.	General Session "12th Annual Cancer Conference" sponsored by the Ohio Division, Inc. American Cancer Society
9:00 A.M.	Ohio Chapter, American College of Chest Physicians
9:00 A.M.	Section on Ear, Nose and Throat and Ohio Society of E.N.T.
10:00 A.M.	Ohio Chapter American Academy of Pediatrics (Executive Meeting)
10:00 A.M.	Ohio Ophthalmological Society Annual Business Meeting
11:00 A.M.	Health Commissioners Institute
11:30 A.M.	OMPAC Luncheon Speaker: Mr. Robert D. Novak Washington, D.C. Washington Columnist and Author
12:00 Noon	Ohio Chapter American Academy of Pediatrics Luncheon
12:00 Noon	Luncheon and Business Meeting Section on Rheumatology
12:00 Noon	Luncheon Ear, Nose and Throat Society
12:00 Noon	Ohio State Society of Thoracic Surgeons Luncheon and Business Meeting

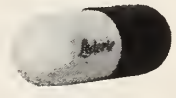
(Continued on Page 520)

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genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
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Rocky Mountain spotted fever
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1970 OSMA Annual Meeting Highlights (Cont.)

WEDNESDAY (Continued)

12:00 Noon	Ohio Ophthalmological Society Luncheon
12:00 Noon	Section on Colon and Rectal Diseases Luncheon
2:00 P.M.	OSMA GENERAL SESSION Speaker: Roger Egeberg, M.D.
3:00 P.M.	Section on Anesthesiology
3:00 P.M.	Section on Colon and Rectal Diseases
3:00 P.M.	Section on Ear, Nose and Throat and Specialty Society
3:00 P.M.	Section on Internal Medicine
3:00 P.M.	Sections on Obstetrics and Gynecology
3:00 P.M.	Section on Ophthalmology and the Ohio Ophthalmological Society
3:00 P.M.	Section and Chapter on Pediatrics
3:00 P.M.	Section on Rheumatology
3:00 P.M.	Health Commissioners Institute
5:30 P.M.	Case Western Reserve Cocktail Party
7:00 P.M.	OSMA Social Function "FAR EAST FLING"

THURSDAY, MAY 14

8:30 A.M.	General and Pre-registration
8:30 A.M.	Breakfast, Ohio Committee on Trauma, American College of Surgeons
9:00 A.M.	All Exhibits Open
9:00 A.M.	General Session "The Conquest of Hypertension— No Longer the Impossible Dream" Program sponsored by the Ohio State Heart Association
9:00 A.M.	Health Commissioners Institute
9:00 A.M.	Section on Occupational Medicine

THURSDAY (Continued)

10:00 A.M.	Executive Committee Meeting, Ohio Committee on Trauma, American College of Surgeons
11:00 A.M.	OSMA GENERAL SESSION Program sponsored by Student AMA Chapters
12:00 Noon	Exhibitors Luncheon, Hosted by OSMA (Technical, Scientific and Health Education)
12:00 Noon	Luncheon for Committee on Scientific Work
12:30 P.M.	Business Meeting, Section on Plastic Surgery
1:00 P.M.	General Session Program sponsored by the Section on Plastic Surgery
1:30 P.M.	Section and Ohio Neurosurgical Society
2:00 P.M.	OSMA GENERAL SESSION Speaker— Dr. Norman Vincent Peale
3:30 P.M.	General Session "The Practical Management of Emergency Room Emergencies" Program presented by the Ohio Committee on Trauma, American College of Surgeons
3:30 P.M.	Combined Section on Directors of Medical Education and Section on General Practice
3:30 P.M.	Section on Physical Medicine and Rehabilitation
4:30 P.M.	Dismantle all Exhibits
5:30 P.M.	Buffet Dinner (Delegates, Alternates, OSMA Officers and Official Guests)
6:00 P.M.	Dinner Physical Medicine and Rehabilitation
6:30 P.M.	Registration—Final Session of House of Delegates
7:00 P.M.	Business Meeting, Final Session of the House of Delegates

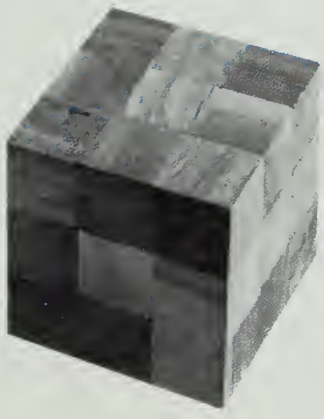
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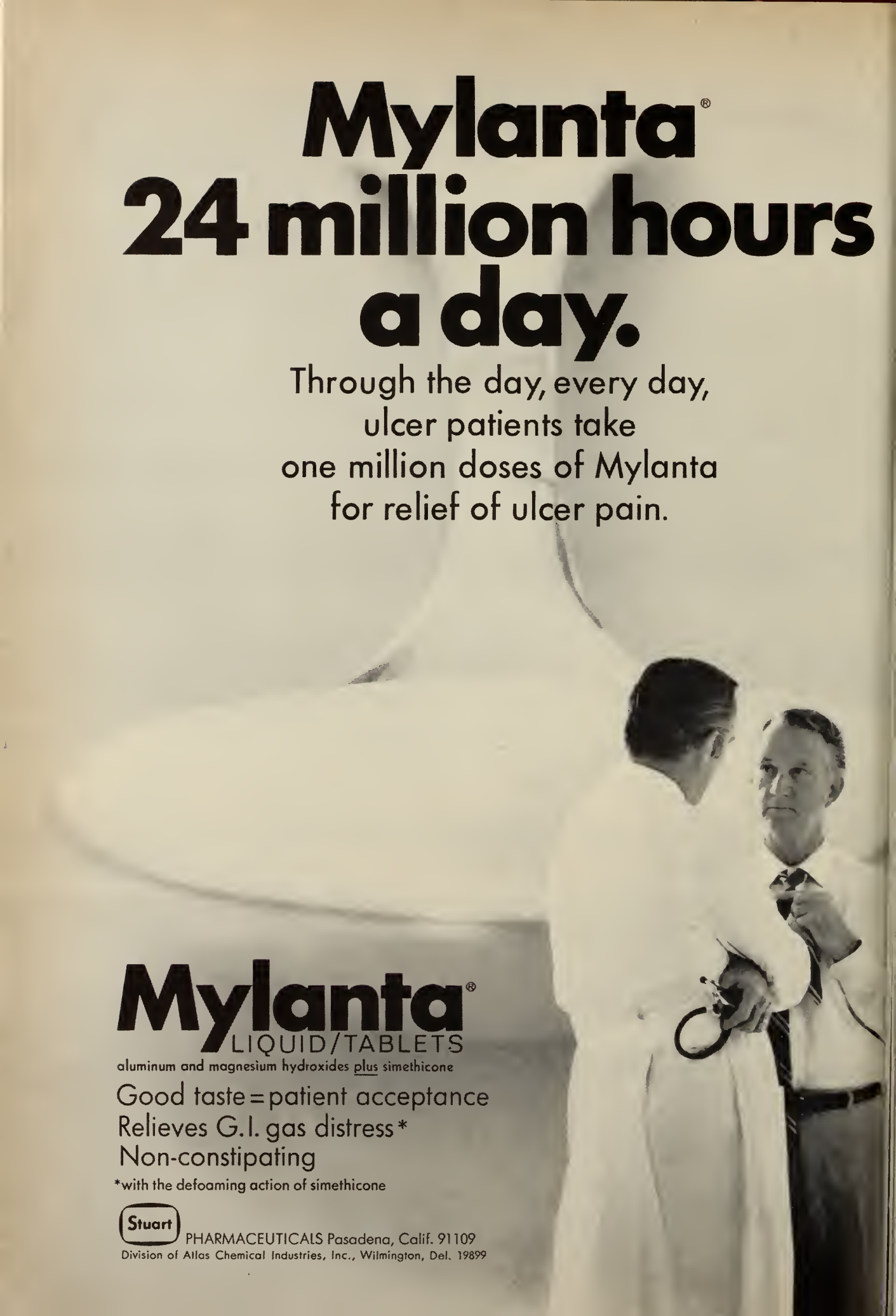
References: (1) Sands, R. X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M. J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest. Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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Visiting Medical Faculty Weekly Seminars — Mercy Hospital, Springfield; 1½ hours, one day a week through May 30, 1970; for specialists and nonspecialists.

Tumor Conference — Youngstown Hospital Association; two hours a day, once a week, through June, 1970; for specialists and nonspecialists.

Electrocardiography Review — Youngstown Hospital Association; 1½ hours a day, two days a month; through June, 1970; for specialists.

Psychiatric Treatment Methods — Veterans Administration Hospital, Brecksville; three hours a day, one day a month, October 8 through May 13, 1970; for specialists and nonspecialists.

May

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown —**Tall Girl Syndrome,** T. S. Danowski, M.D., University of Pittsburgh, May 7; **Glomerulonephritis,** Alvin Shapiro, M.D., University of Pittsburgh, May 21; **Infectious Hepatitis,** Edward Rotheram, M.D., University of Pittsburgh, May 28.

One Week Physician Course—Nuclear Medicine — May 11-16; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

1970 Annual Meeting, Ohio State Medical Association, Columbus, May 11-15; hours of postgraduate short courses; general session, specialty section and specialty society programs.

Prevention of Cancer—St. Elizabeth Hospital, Youngstown, May 14, Emmanuel Farber, M.D., Ph.D., chairman, Department of Pathology, University of Pittsburgh.

Radiology—Annual Meeting of the Ohio State Radiological Society, May 15-17 at the Cleveland-Sheraton Hotel, Cleveland; convention chairman, Theodore J. Castele, M.D., Lutheran Hospital, 2609 Franklin Blvd., Cleveland 44113.

Kidney Disease Symposium — University of Cincinnati Medical Center, May 20.

The Changing World of Medicine, Sixteenth Annual Seminar sponsored by the Huron Road Hospital and the Cleveland Chapter of the American Academy of General Practice, at the Severance Center, Mayfield and Taylor Roads in Cleveland Heights May 20-21. Contact the Hospital medical staff, 13951 Terrace Road, Cleveland 44112.

Advances in Dermatology — Cleveland Clinic Educational Foundation, May 21-22; for specialists and nonspecialists.

Tuberculosis and Respiratory Diseases — Cleveland-Sheraton Hotel, Cleveland, May 24-27; sponsored by the American Thoracic Society and National Tuberculosis and Respiratory Disease Association, 1740 Broadway, New York 10019.

Refresher Course in Diagnostic Radiology — University of Cincinnati Medical Center, May 24-29.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; May 11 — "Virilism," Drs. C. McGowen and N. Suanprasert; May 25 — "Hypertension in Primary Renal Disease," Drs. R. Bacani and S. Young.

Evaluation of the Hypertensive Patient, May 27, Trumbull Memorial Hospital, Warren.

June

Children's Hospital, Akron, Resident-Alumni Days, June 2-3.



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Continuing Education

Reasoned Approach to Surgery of Thyroid Malignancies, and Pitfalls in Management of Blunt Trauma, Youngstown Hospital Association, South Unit, June 4 at 8:00 a.m.: Alexander J. Walt, M.D., Detroit, speaker.

Visiting Professor of Medicine Series: St. Elizabeth Hospital, 1044 Belmont Ave., Youngstown —**Pericarditis,** James Leonard, M.D., University of Pittsburgh, June 4; **GI Bleeding, Etiology Undetermined; Malabsorption,** George Gabuzda, M.D., Case Western Reserve University, June 18.

Otologic Surgery, Using Live Color Television — University of Cincinnati Medical Center, June 5-9.

One Week Physician Course—Nuclear Medicine — June 8-13; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; June 8 — "Fungal Infections of the Skin," Drs. K. Lloyd and B. Thimmappa; June 22 — "Diabetic Neuropathy," Drs. L. Green and W. Tsang.

Second Annual Urologic Outing on Controversies in Urology — Sponsored by The Ohio State University Division of Urology at Burr Oak State Park, Ohio, on June 29, 30, and July 1. Modern, air-conditioned facilities. Please contact Program Director Chester C. Winter, M.D., Division of Urology, Ohio State University Medical Center, 410 W. 10th Avenue, Columbus 43210.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

August

Ohio Academy of General Practice, Annual Assembly, August 4-6, Sheraton-Columbus Motor Hotel, downtown Columbus; contact the OAGP.

September

Eleventh Annual Pediatric Postgraduate Conference sponsored by OSU College of Medicine, Department of Pediatrics, and the Columbus Children's Hospital, September 24-25; Contact Center for Continuing Medical Education, OSU College of Medicine, 320 W. Tenth Ave., Columbus 43210.

Ohio Chapter, American College of Surgeons, Neil House Motor Hotel, Columbus, September 25-26; Charles G. Livingood, M.D., Secretary, 211 S. Main Street, Dayton 45402.

Psychiatric Clinic Directors Schedule Meetings

In order to revitalize its scope in the outpatient psychiatric field, the Ohio Association of Psychiatric Clinic Directors has announced a series of meetings with outstanding key speakers to lead discussions.

In addition to psychiatrists who work in the various community mental health clinics in Ohio, officers are inviting other professional personnel and their friends to these meetings. Stress will be on various issues of community psychiatry and ways to improve patient care.

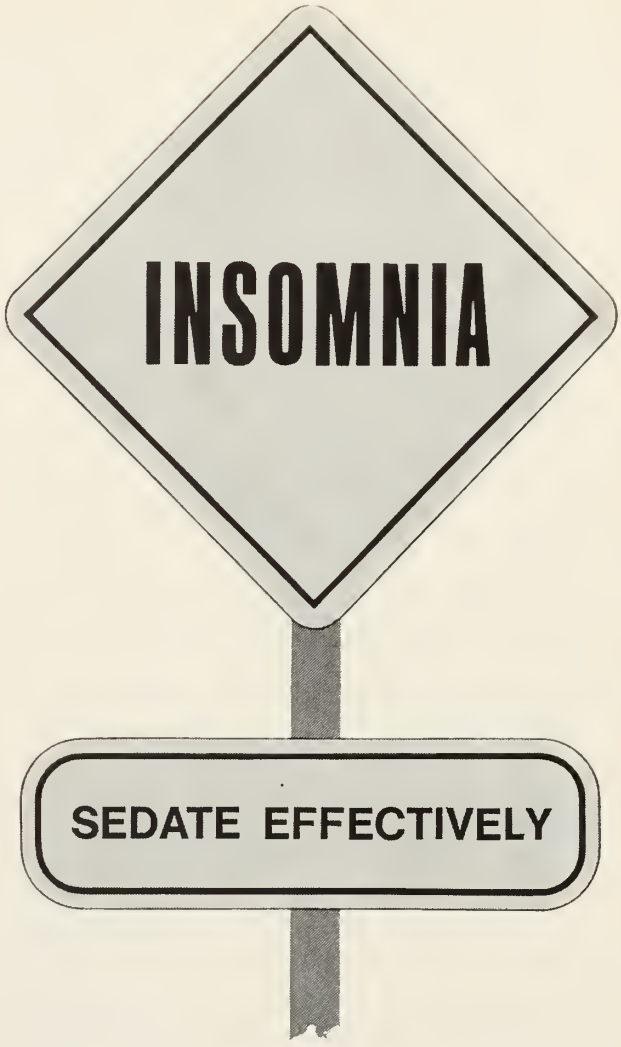
The first of the series of meetings was scheduled on April 30 with Dr. Cooper of Ann Arbor, Mich., speaking on "Mental Health Consultations." The following three meetings have been announced for future months, all of them scheduled in Columbus.

September 25—"Making an Outpatient Clinic More Comprehensive," with Dr. Wolford, of Pittsburgh, as speaker.

November 20—"Community Organization and Development," with Dr. Hitchcock, of Pittsburgh, as speaker.

January 22, 1971—"Administration and Communication," with the guest speaker to be announced.

Officers of the organization are the following: Robert M. Edwards, M.D., Marion, president; Roberto Pagarigan, M.D., Tiffin, president-elect; and Theodor Bonstedt, M.D., 3009 Burnet Ave., Cincinnati 45219, secretary-treasurer. Advance registration is required, and persons interested are invited to contact Dr. Bonstedt at the address indicated.



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ON THE OMPAC FRONT

Get Your Congressman's Ear on Runaway Spending

The next time you have a chance to talk with or write to your Congressman and when interviewing announced candidates for Congress in the November election, ask them if they are willing to support an over-hauling and house-cleaning of the Executive Branch of the Federal Government which is loaded down with duplication and confusion, according to the *Scripps-Howard Washington Bureau*. To wit:

- Eight cabinet departments and 12 so-called independent agencies administer federal health programs.

- Eighteen agencies run programs to improve our environment.

- Ten cabinet departments (the only exceptions being Post Office and Transportation) and 15 agencies are involved in education.

- There are at least 35 separate federal housing programs, 20 separate transportation projects, 27 different agencies involved with utilities, 28 engaged in recreational and cultural activities and 62 in providing community assistance facilities.

- There are about 1000 federal projects under way in the field of pollution. These projects are being managed from 192 installations by nine departments and agencies.

- A Library of Congress study contends that the "Federal Government spends nearly $4 billion annually on research and development in its own laboratories, but it does not know exactly how many laboratories it has, where they are, what kinds of people work in them or what they are doing."

- About 33 federal agencies are engaged in almost 300 consumer protection activities.

- No one can even guess how many federal programs deal with "urban affairs." But Ribicoff's staff has determined, for example, that in Oakland, Calif., there are 140 separate urban projects being administered by seven different federal departments.

You might suggest that it is time for another hard look at Federal government management which is spending, give or take a little, $5515 every second.

It's important to you that those who represent you in Congress give more than just lip service to straightening out the most expensive and complicated enterprise in the World.

Millions of Hours Given by VA Volunteer Workers

Volunteer workers at Veterans Administration hospitals are working longer and more effectively, Administrator of Veterans Affairs Donald E. Johnson told the National Advisory Committee for VA Voluntary Service (VAVS).

At the Advisory Committee's 24th annual meeting in Washington, D.C., the administrator reported that more than nine million hours were contributed by volunteer workers last year at the 166 VA hospitals and outpatient clinics. The number of workers averaged 110,000.



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Investment Prognosis

By Frank Van Holte, Columbus

ALL OF US HAVE HEARD TALES of the unfortunate investors who lost their fortunes by investing in companies engaged in the manufacture of street cars, wagon wheels, buggy whips and other products now long outmoded in our modern society. Those investors buried their stock certificates in a safe-deposit box and proceeded to forget them. Then finally they became aware that the companies manufactured products that became obsolete and outmoded, and business declined along with the value of the stock. In fact, you have to admit your age when you tell such stories. But the interesting point is that such stories could be told today without mentioning horse and buggy products. The public's acceptance of a company's product can quickly be affected by a new discovery in a particular field—such as a new drug, a new cost lowering process developed by a competitor, or even a simple change in fashion.

The intense competition in business today is apparent to everyone and, as investors, we must be concerned and aware of these changes. Today's alert investor also looks for new products, new companies, and even new industries. Restaurant chains, companies dealing with television, computers, jet aircraft, plastics, copying machines, and missile and space products can certainly be classified as investment opportunities introduced to the current generation. And some old or new companies will become leaders in manufacturing products or introducing services to solve some of the pressing problems of this age, such as pollution, housing, and traffic problems. Fortunes will be made by timely investments in the right companies in the right field or industry. The price of successful investing is eternal vigilance as to the pulse of the public.

This problem of vigilance is surely one of the prime reasons for the tremendous success of the mutual funds. Most investors simply do not have the time to engage in the research necessary for the intelligent and prudent investment of their savings. They depend, instead, on the skills, training, and abilities of portfolio managers of these mutual funds. Of course, another solution is to utilize the services of your experienced stockbroker. A good broker takes time to be informed and too many investors do not utilize the service offered by these professionals before they make a commitment in the investment of their funds. If a broker cannot answer your questions, at least you should utilize his time and facilities to seek the answer or to give you an intelligent appraisal of the investment question. So, I am suggesting that in making your investments you utilize and employ the professional services available.

In reporting to you on the judgment of many of the market experts, it now appears that the recent reduction of the prime lending rate from 8½ percent to 8 percent has substantially reduced the number of economists with a bearish outlook. Granted that we must accept lower corporate profits and other economic weaknesses in the coming months, an appraisal of the future does not forecast a serious economic slump. In fact, it now seems very apparent that the long term trend of the economy is up and up, with inflation continuing to weaken our savings accounts. Notwithstanding the high interest rates, business loans have increased steadily and the investment calendar indicates a continued heavy schedule of industrial, finance, and utility financings. This certainly seems to be a demonstration of confidence in the strength of the economy.

If you tend to be conservative, with a basic interest in income and stability, I suggest you look at the utilities. They are now selling at depressed prices with high yields and, in addition, offer good prospects of a moderate capital growth. If you can sacrifice income for the opportunity to achieve growth in value, investigate the building and loan

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This monthly feature is written for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

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company investment opportunities. When the money market becomes more stable, many of these companies should show substantial earnings growth because of the pent-up demand for housing.

Mergers and consolidations are wrecking old time traditions. Can you imagine the old established Cincinnati Milling Machine Company entering the computer market? How about Abbott Laboratories manufacturing golf balls? Did you know that the Ford Motor Company produces Philco appliances; the Eastman Kodak Company manufactures vitamins; the Hershey Foods Corporation produces Cory Coffeemakers; and Swift and Company owns a life insurance company? And, believe it or not, the RCA Corporation publishes books (Random House) and rents cars (Hertz Corp.). Of course, there are many other examples of unusual consolidations. Surely the name of the corporation no longer identifies the product. Who would have imagined that life insurance companies would be organizing and selling mutual funds?

It is within the realm of possibilities that within another generation or two all of the corporations in America will be owned and controlled by a few super corporations and these super corporations, in turn, will be largely owned by a few super mutual funds. What a thought!

Dr. Harold B. Elliot was presented a meritorious service award at the annual corporation meeting of Community Hospital of Springfield and Clark County for his outstanding continuous service to the hospital. A similar award was given to Wesley T. Harrison for outstanding contributions to health care on a community-wide basis.

Drug Abuse Pamphlet Gets Wide Distribution

An example of the public's interest in combating drug abuse is reflected in an unusually high demand for a pamphlet on this subject offered for distribution by the Ohio State Medical Association's Committee on Mental Health.

A total of 41,636 copies of the pamphlet, prepared by the Department of Health Education of the American Medical Association and endorsed by the OSMA, were distributed on request during the period October 20, 1969 to February 10, 1970.

The following breakdown of where these pamphlets on drug abuse were distributed is interesting:

Schools (guidance counselors, teachers, parents)	13,915
County Medical Societies	5,820
Physicians (waiting rooms, talks, service clubs)	4,325
Law Enforcement People	3,300
Miscellaneous	2,735
Ohio Department of Health (and county health agencies)	2,406
College Students and Educators	2,300
4-H Clubs, Extension Groups	2,240
OSMA Officers, Councilors, & Dr. Budd	1,600
Girl Scouts, Boy Scouts, and Campfire Girls	1,570
Clergy	1,305
Libraries	70
Ohio Rural Health Council Members	50
Total	41,636

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Obituaries

Monroe Cronstine, M.D., Toledo; Vanderbilt University School of Medicine, 1919; aged 73; died March 9; member of the Ohio State Medical Association and the American Medical Association; practicing surgeon for many years in the Toledo area.

Arville Ottis DeWeese, M.D., Kent; University of Louisville School of Medicine, 1924; aged 81; died March 10; member of the Ohio State Medical Association and the American Medical Association; retired in 1965 after 41 years association with the Kent State University's health service which he helped found; former president and one of the founders of the American School Health Association; member of the Methodist Church; survived by his widow, three sons, and a daughter.

Otto Louis Goehle, M.D., Cleveland and Lakewood; Cornell University Medical College, 1905; aged 93; died March 11; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics; practitioner of some 62 years standing in the Greater Cleveland area; past president of the Academy of Medicine of Cleveland; former faculty member at Case Western Reserve University School of Medicine; survived by his widow, and a sister.

Joseph Charles Hall, M.D., Youngstown; University of Louisville School of Medicine, 1931; aged 65; died March 10; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; general practitioner in Youngstown since 1933 and an earlier resident in that city; also physician for the Youngstown Boxing Commission; member of the Christian Church; survived by his widow, two sons, his mother, two brothers, and a sister.

Ralph Elton Hershberger, M.D., Cleveland; Western Reserve University School of Medicine, 1925; aged 70; died February 21; former member of the Ohio State Medical Association; past president of the Seneca County Medical Society; living in retirement in recent years; practitioner for 38 years in Tiffin; former member of the Tiffin Board of Health; member of the Masonic Lodge and the Kiwanis Club; veteran of World Wars I and II; survived by his widow and two sons.

Roland Allen Leslie, M.D., Cincinnati; University of Cincinnati College of Medicine, 1941; aged 52; died February 24; member of the Ohio State Medical Association, the American Medical Association, and the American Psychiatric Association; diplomate of the American Board of Psychiatry and Neurology; practitioner in Cincinnati for about 20 years, specializing in psychiatry; consultant for the Hamilton County Probate Court; veteran of World War II; survived by his widow, two sons, a daughter, his mother, and a sister.

Bruce Emerson Lindsey, M.D., Columbus; Starling-Ohio Medical College, Columbus, 1910; aged 83; died March 25; former member of the Ohio State Medical Association and the American Medical Association; member of the American Geriatrics Society; practitioner of long standing in Columbus; retired in recent years; member of the Presbyterian Church; survived by three daughters, and a brother.

Dean Willard Mallet, M.D., Springfield; Ohio State University College of Medicine, 1942; aged 51; died March 16; member of the Ohio State Medical Association and the Industrial Medical Association; general practitioner and industrial physician in Springfield and in recent years associated with emergency service at Community Hospital; veteran of World War II; survived by his widow, four sons, a daughter, and his father.

George Anthony Meyers, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1936; aged 65; died March 16; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; general practitioner and industrial physician in the Blue Ash area of Greater Cincinnati; medical officer for the Post Office Department; deputy coroner for Hamilton County; veteran of World War II; survived by a step-son, a step-daughter, two sisters, and a brother.

Augustine Peller, M.D., Bettsville; Faculty of Medicine, University of Budapest, 1938; aged 60; died March 4; member of the Ohio State Medical

Association; native of Hungary; general practitioner in the Bettsville area for about three years; previously practiced at Avon Lake; survived by his widow, three sons, and a daughter.

Leo Joseph Peters, M.D., Cleveland; Stritch School of Medicine of Loyola University, 1919; aged 73; died March 1; member of the Ohio State Medical Association; general practitioner and health officer in Cleveland for many years; associated with the Cleveland Health Department for about 20 years; survived by his widow, a son, a step-son, three sisters, and two brothers.

Howard Hoyt Shiras, M.D., New York City; University of Kansas Medical College, 1912; aged 86; died February 23; former member of the Ohio State Medical Association; member of the American Academy of Ophthalmology and Otolaryngology; practiced in Cleveland from 1918 until his retirement in 1946; veteran of World War I.

Albert Max Weilbauer, M.D., Maumee; University of Heidelberg, Faculty of Medicine, 1919; aged 77; died March 6; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; native of Germany; general practitioner in the Maumee and Toledo area for 25 years; survived by his widow, and four brothers.

Vytas Elly Zymantas, M.D., Toledo; University of Kaunas, Lithuania, 1941; aged 66; died March 20; member of the Ohio State Medical Association; native of Lithuania; resident of Toledo since the early 1950s and practitioner there for a number of years.

Pamphlet Promotes Blood Donations

An attractive leaflet suitable for distribution to the public in the interest of blood donations has been issued by the American National Red Cross. It is entitled, "The 20 Most Common Excuses for Not Giving Blood" and presents brief discussions to counteract these excuses.

Persons in the Ohio area who wish copies of the leaflet for distribution are invited to contact the following office: Blood Program, Eastern Area, American National Red Cross, 615 N. St. Asaph Street, Alexandria, Va. 22314.

Health Care Capsules

Sensational newspaper headlines and the use of half-truths have caused a large number of the people to believe that physicians are receiving the greatest share of the expenditures for the Medicare and Medicaid programs. As the following table indicates, M.D.s received less than one dollar out of seven of the $20 billion total.

Government Expenditures for Health Services and Supplies (Under all Federal, state and local public programs)

Fiscal Year 1968-69

	Dollars in Millions	Percent of Total
Hospital care	$11,263	55.9%
Physicians' services	2,702	13.4
Other health services *	2,162	10.8
Nursing home care	1,798	8.9
Government public health authorities	1,077	5.4
Drugs and sundries	326	1.6
Administration	314	1.5
Dentists' services	262	1.4
Other professional services	165	.8
Eye glasses and appliances	51	.3
Total	$20,120	100.0%

* Almost all of this is for Defense Department hospital and medical care, including expenditures for military dependents.

EDITOR'S NOTE: *The above is the first of a series. The purpose is to inform the membership of pertinent facts about health care. The content will be intentionally brief and will present only a few significant facts in each issue. We trust that readers can thus more easily remember such information and use it as appropriate in discussions with patients and others. "Capsules" will be prepared by OSMA Director of Economic Research, Charles F. Price. If you need explanation or elaboration on any of the data, please direct your requests to him at the OSMA office.*

A 60-page illustrated brochure recently was issued by the Akron Area Medical College and Educational Foundation detailing the latest study favoring location of Ohio's next medical school at the University of Akron.

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

CONVENTION may be in progress or perhaps over before you read this column, and we all soon will be saying, "Wasn't it wonderful?" There is something about getting together and sharing ideas with other auxiliaries that has to be experienced to be appreciated. If you were there, you know what I mean. If you were not, read the coming report to see what you missed.

In spite of the mail strike, snow storms and Easter vacation, recent correspondence indicates that state board members have been hard at work. Mary Rogers Smith (Mrs. Clarence V.), legislative chairman, arranged "A Day at the Legislature" for elected officers of our state auxiliary late in March. This program was recommended by National as a step in better understanding the workings of government.

A few days earlier auxiliary members had the opportunity to hear Mrs. Patricia Hitt discuss "The Role of the Volunteer in Meeting the Needs of Mothers and Children" at a meeting of the Ohio Association of Maternal and Child Health in Columbus. Our chairman on Children and Youth, Mary Lou Haverland (Mrs. H. W.), had arranged for this invitation and, hopefully, will give us a report at a later date.

County presidents have been hearing from State President Ruth Meltzer and communications chairman Ludel Sauvageot about convention plans, deadline dates and dues.

Action at the County Level

Many counties faithfully report their monthly activities for publication in this column. If a story has not appeared, it is due to timing or availability of space. Let's catch up now on the accumulated news from the grass roots of the auxiliary.

The *News Capsule* from **Stark County** indicated a variety of mid-winter activities in progress. In February the auxiliary met for a Gala Style Show by Halle's at the Imperial House in Canton. Wives of House Doctors in the hospitals were special guests.

The March meeting was held at Mt. Union College in Alliance. Mr. Yost Osborne discussed the history of the college. Following lunch in the Campus Center, auxilians toured the college.

A major fund raising event in April was the dinner dance "Swing and Sway with Sammy Kaye." Proceeds from this event are used for a variety of programs in community health, mental health, rural health, and human growth and family development, as well as for scholarships and *Today's Health*. Practical birthday gifts for patients at Massillon State Hospital were collected at the regular monthly meeting of the auxiliary in April.

Rubella Vaccination

Many auxiliaries across the state were involved in the anti-rubella campaigns during the month of March. **Erie County** reported that auxiliary president Mary Shirball headed the publicity for the drive sponsored by the Erie County Medical Society, Osteopathic Society, their auxiliaries and the pharmaceutical organization. Clinics were held at five sites on Sunday, March 1.

In April members of the **Erie County Auxiliary** traveled to Columbus at the invitation of

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

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Ethel Swanbeck to observe state government in action. They visited the offices of several state officials, attended a meeting of the Finance Committee and listened to the afternoon session of the Legislature.

Mrs. Jack MacDonald opened her home in Forest Park for the March meeting of the **Woman's Auxiliary to the Scioto County Medical Society.** Guest speakers for the afternoon were Scioto County Prosecutor Everett Burton and Alvin F. Lau, Portsmouth, resident agent for the Federal Bureau of Investigation in the Cincinnati Division. Their respective topics were "Self Defense" and "Jurisdiction of the FBI." Assisting Mrs. MacDonald as hostesses were Mrs. Louis R. Chaboudy, Mrs. William C. Hugenberg and Mrs. Donald M. Appleton.

Fashion Show Scores Three Ways

The fashion show given on St. Patrick's Day by the **Woman's Auxiliary to the Academy of Medicine of Cincinnati** was successful in three ways. First, it was a fund raising event for the philanthropic activities of the auxiliary. Second, it netted good coverage in the Cincinnati *Post-Times Star.* And third, it was a great way to recognize all the hard-working committee chairmen of the auxiliary.

The event can best be summed up by quotes from Margaret Weaver's news story: " 'The Chic You' will feature smart women in smart clothes. The Woman's Auxiliary . . . is calling on its bright committee chairmen to model fashions . . . whimsical St. Patrick's Day mood will be stated in table decorations of green carnations . . . The emphasis behind all this fashionable charm goes deeper. The Auxiliary's stress is on the creative approach used and the progress made in its volunteer areas." This is followed by details of three projects from an interview with Mrs. John J. Fleming, chairman of the Apple Tree Nursery; Mrs. Lawrence G. Kautz, chairman of the Health Careers program; and Mrs. Robert R. Pierce, chairman of the Community Service Committee.

Fairfield Honors Member

At the March meeting of the **Fairfield County Medical Auxiliary,** the outstanding contributions of one of its members to the Para-medical Careers program were formally acknowledged by the presentation of the following resolution:

"Whereas Eleanor Jasper has given countless hours in the interest of our Para-medical Careers program may the following report be written into our permanent record.

"Mrs. Jasper presented the original motion in 1950 that established our Nurse Scholarship Fund.

"She served first as a committee member in 1957. In 1958 she was chairman of Scholarship and Nurse Recruitment.

"In 1962 she again chaired this committee and has served in that capacity to the present time.

"Under her capable leadership Para-medical Career Clubs were formed in most of the county high schools.

"She is responsible for organizing the Candy Striper program for Lancaster Fairfield Hospital in 1962. Thus far 746 girls have participated as candy stripers. 360 other para-medical career club members have served in many community projects through the years.

"The nurse scholarship program has reached an enviable level of success during her chairmanship.

"Whereas Mrs. Jasper has touched the lives of 1106 young girls as they have participated in the varied programs and opportunities she has provided consistently for eight years,

"Resolved, we so honor her today."

"Listen, Listen, Listen!"

This was the plea of teen-agers at a recent Youth Health Conference in Cincinnati. Communication is a two-way street on which listening is as important as talking.

Auxiliary member Kay Mazur was largely responsible for the theme and format of the Ninth Annual Health Conference co-sponsored by the Health Department Volunteers (of which Kay is a Board member), Council of PTAs, Academy of Medicine, and Associated Health Agencies. Mrs. Mazur was originally inspired by Wisconsin's program "Youth on a Four-Day Trip" as presented in the January 1969 issue of *MD's Wife.*

A student planning board was formed with representatives from five selected high schools. The board planned and conducted a seminar on March 1, tackling the topics of drugs, sex, alcohol and emotional problems. The small discussion groups were led by student moderators with a technical or professional person acting as a resource. Then members of the teen-board presented the results of their discussion to the adult conference, "Dialogue for a Gapped Generation" on March 18.

Students from Circleville presented the Family Service play "Let's Get Basic" to start the afternoon session of the adult conference. Group discussion followed with most of the emphasis on problems in dealing with youngsters. Again, the question of the communication came up. One teen-ager had this suggestion: "If each of you (adults) would ask your son or daughter to invite

eight or ten friends into your home for a talk, think how many could be reached."

Mrs. Mazur feels that medical auxiliaries can do much to encourage better communication with today's youth. We have the resources—printed material and informed personnel. She called my attention to the current program in Wisconsin co-sponsored by the state medical society and the auxiliary. "The Drug Turn On" was an intensive, week-long TV educational campaign in which nationally known and local experts gave viewers blunt information about the deadly hazards of using drugs as an escape hatch from life. Hope you read about it in the March 1970 issue of *MD's Wife*.

One further point made by Mrs. Mazur was that auxiliaries should work with other interested agencies and/or organizations. We should not waste time and motion in duplicate or parallel efforts but should work cooperatively. She demonstrated this effectively herself when planning the Health Conference.

Delegates Needed for National Convention

The annual meeting of the Woman's Auxiliary to the American Medical Association will be held in Chicago, June 21-25. Headquarters will be at the Drake Hotel, where a block of rooms has been set aside for the Auxiliary. Check the May issue of *MD's Wife* for an abstract of the program.

Are you going to Chicago? Please send your name to Mrs. Lucile Egger at the Central Office, 4770 Indianola Avenue, Columbus, Ohio 43214 as soon as possible if you are planning to attend. Delegates and alternates will be elected at the state meeting in May and it will expedite things to have names in advance.

A few details may assist you in planning ahead. There will be a reception honoring the national president and president-elect from five to seven o'clock at the Drake Hotel on Sunday, June 21. Auxiliary members, husbands and guests are cordially invited to this event. The formal opening of the convention will be at 9:00 a.m. on Monday, June 22. Business sessions will be held both morning and afternoon that day. "Show and Tell" exhibits demonstrating activities of county and state auxiliaries will be open at 4:00 p.m.

The annual luncheon honoring AMA Board of Trustees and wives is scheduled for Monday noon with AMA President Dr. Gerald D. Dorman as guest speaker. Tuesday's luncheon will honor National Past Presidents and honorary members. Following luncheon the Kenosha Community Home-makers Home Health Aid Service will present a pageant of costumes worn by women down through the ages with authentic reproduction of hair styles, make-up, jewelry and accessories.

On Tuesday there will be reports and voting for the 1971 nominating committee. Wednesday's general morning session will include amendments, resolutions, reports and installation of the 1970-71 officers.

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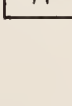
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See Issues of Alternate Months Beginning with February



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Pediatric Conference Scheduled in Columbus

The Eleventh Annual Pediatric Postgraduate Conference, sponsored by the Ohio State University College of Medicine, Department of Pediatrics, and the Columbus Children's Hospital, will be held on September 24 and 25, 1970.

Guest speakers will include: Murray Feingold, M.D., director, Center for Genetic Counseling and Birth Defect Evaluation, Boston Floating Hospital for Infants and Children, New England Medical Center Hospital, Boston; John Opitz, M.D., assistant professor of pediatrics and medical genetics, University of Wisconsin, School of Medicine; and Peter Pochi, M.D., associate professor of dermatology, Boston University Medical Center, Boston.

The Samuel D. Edelman Lecture will be given by Dr. Feingold on the evening of September 24 at a dinner in conjunction with a meeting of the Central Ohio Pediatric Society. Registrants for the conference are invited and may bring additional guests at a cost of $7.00 each.

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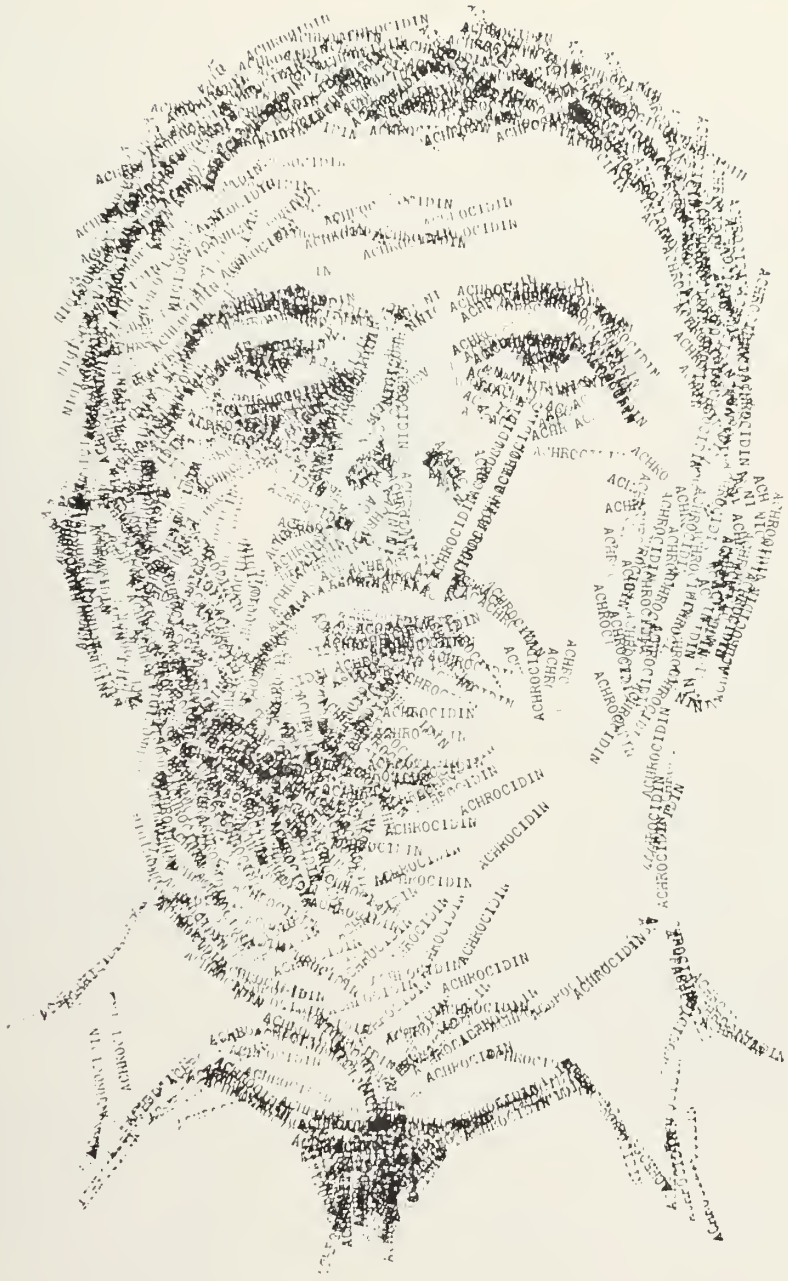
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Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

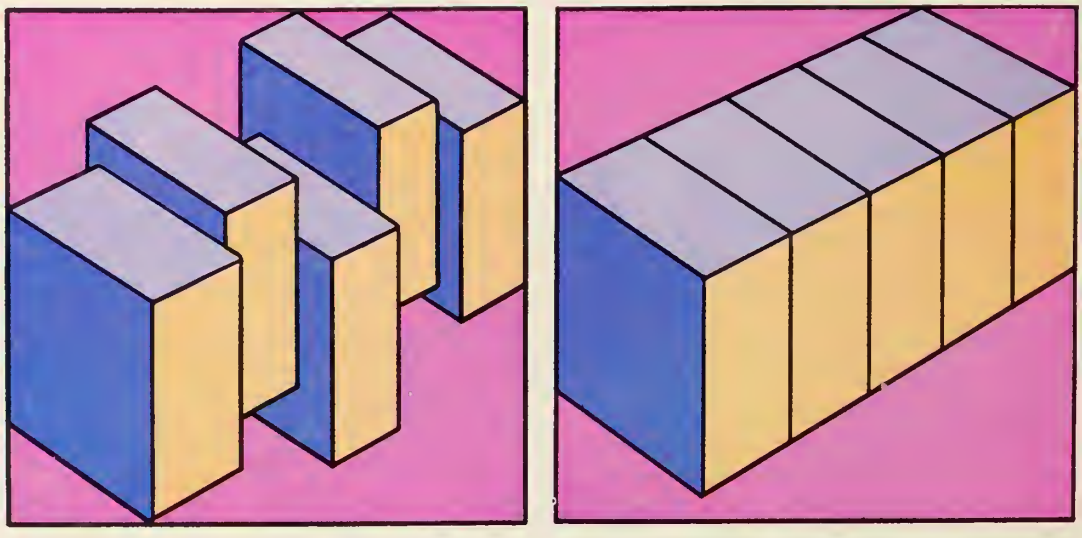
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
PRECAUTIONS: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
ADVERSE REACTIONS: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido--all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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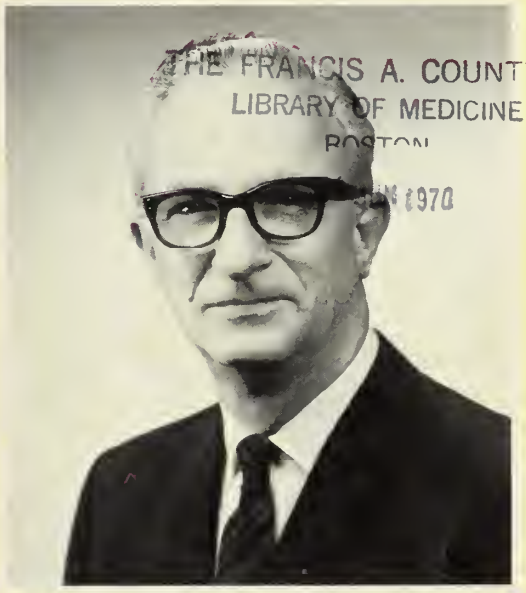
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JUNE, 1970
Vol. 66 • No. 6

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PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION


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LIBRARY OF MEDICINE
BOSTON
JUN 1970

Frederick T. Merchant, M.D.

President, Federation of State Medical Boards

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Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., 9-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, .: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., ., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

Medical Care U. S. A. And the Trojan Horse of 1970

By Robert E. Howard, M.D., Cincinnati

IS AMERICAN MEDICINE A FAILURE? Are people dying in the streets for want of medical care? Does American medicine lack the confidence of the people? Is it self-centered?

One of America's most respected pollsters reports, "NO"—in capital letters. The "Lou Harris" poll shows that 88 percent of the people applaud and approve the methods of delivery of medical care of the physicians of this nation.

This hardly reflects the claim of the politicians, the bureaucrats and the socialists that Americans have lost faith in their physicians and, therefore, medical decisions must be made by politicians and not by medical men.

We are told that times change, and medicine must change with it.

We are told that the system of medical care must be changed because there are certain groups that can't afford medical care.

Didn't anybody ever think that it is ridiculous to tear down a highly successful system to attempt to meet the needs of a group who have not been able to succeed in maintaining themselves or take advantage of free medical service when made available. In other words, the Lou Harris survey revealed that most patients highly regard their personal doctor and would rather feel that the doctor is working for them instead of the federal government.

Recent reports of the Senate Finance Committee gave the news media a chance to distort the facts about Medicare and Medicaid and the following headlines concerned me—and I hope you—with Medical Care U.S.A again at the crossroads:

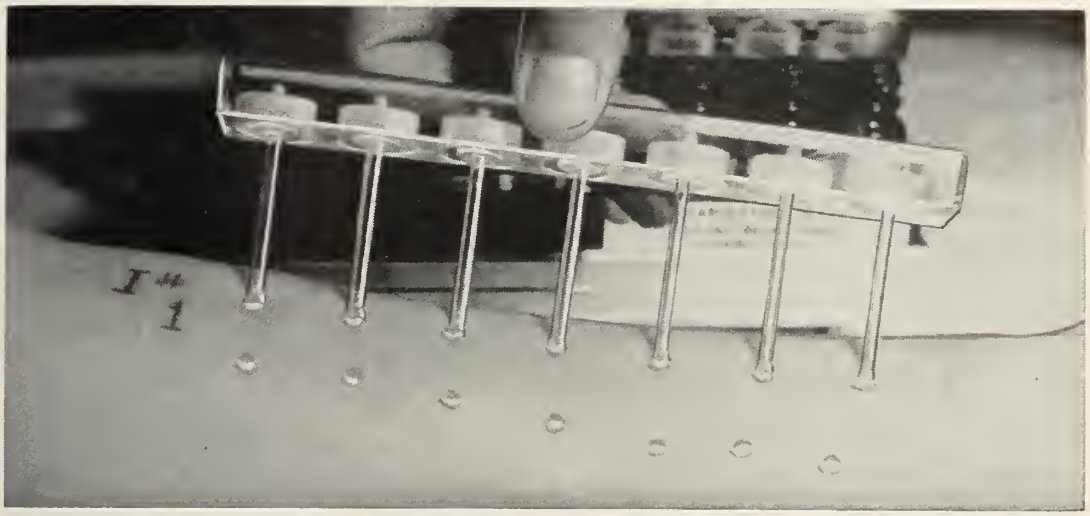
> "Medicine Needs New Management"; "National Health Insurance Inevitable"; "Prepayment Plans Get Old School Ties"; "Health Care Needs Overhaul"; "Private Practice Is as Dead as a DODO Bird"; "White Hope for Lowering Medical Costs"; "Unions Plan Huge Medical Center on Prepayment Program"; and the recent articles in January 1970 *Fortune Magazine* on "Our Ailing Medical System."

American Medicine, as one article states, "Once a source of national pride, now stands on the brink of chaos." One of the writers claims, "Much of U.S. Medical Care is inferior in quality, wastefully dispensed, and inequitably financed." The main factor in the rising medical costs, according to *Fortune Magazine* Articles, is the archaic manner in which medical care is arranged, distributed and paid for. Then there is the statement: If health care is organized systematically and prices are controlled, the incentives can work for the consumer. This statement, along with the articles recommending comprehensive prepaid medical care, led me (as a private, single specialty group practitioner and at my own expense) to the West Coast for interviews in and out of several of the facilities of Kaiser Permanente Foundation Medical and Hospital Units. This type of prepaid Group Practice was recommended by several articles as the efficient and quality system with better care at less cost.

My casual observations of such a plan, when interviewing some of the doctors and patients in and out of the system, revealed weakness in the structure of the system, since it was evident that there is no free choice of physician but the patient is assigned one. There is also a lack of continuity of medical care. In some areas that are crowded, there is some concern with the overutilization of the system to provide health maintenance and periodic examination which is included in the prepaid program negotiated. To aid the backlog of appointments for this health service, the development of an automated multiphasic screening program recently has been instituted to cope with the problem. The doctors have recommended that all patients calling for an appointment be screened; those with symptoms of disease are to be seen by a physician; and those with minimal complaints are to be cleared through the multiphasic screen-

Dr. Howard is a practicing physician in Cincinnati, a Past President of the Ohio State Medical Association, and an Alternate Delegate to the American Medical Association.

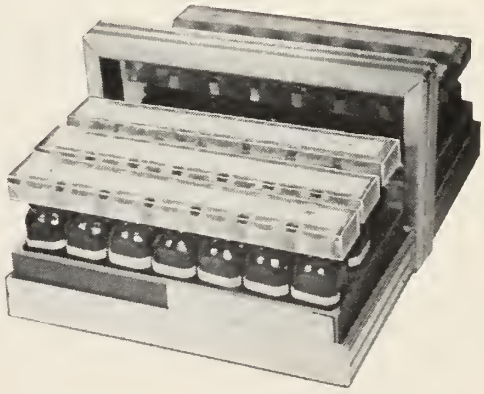
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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during April. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

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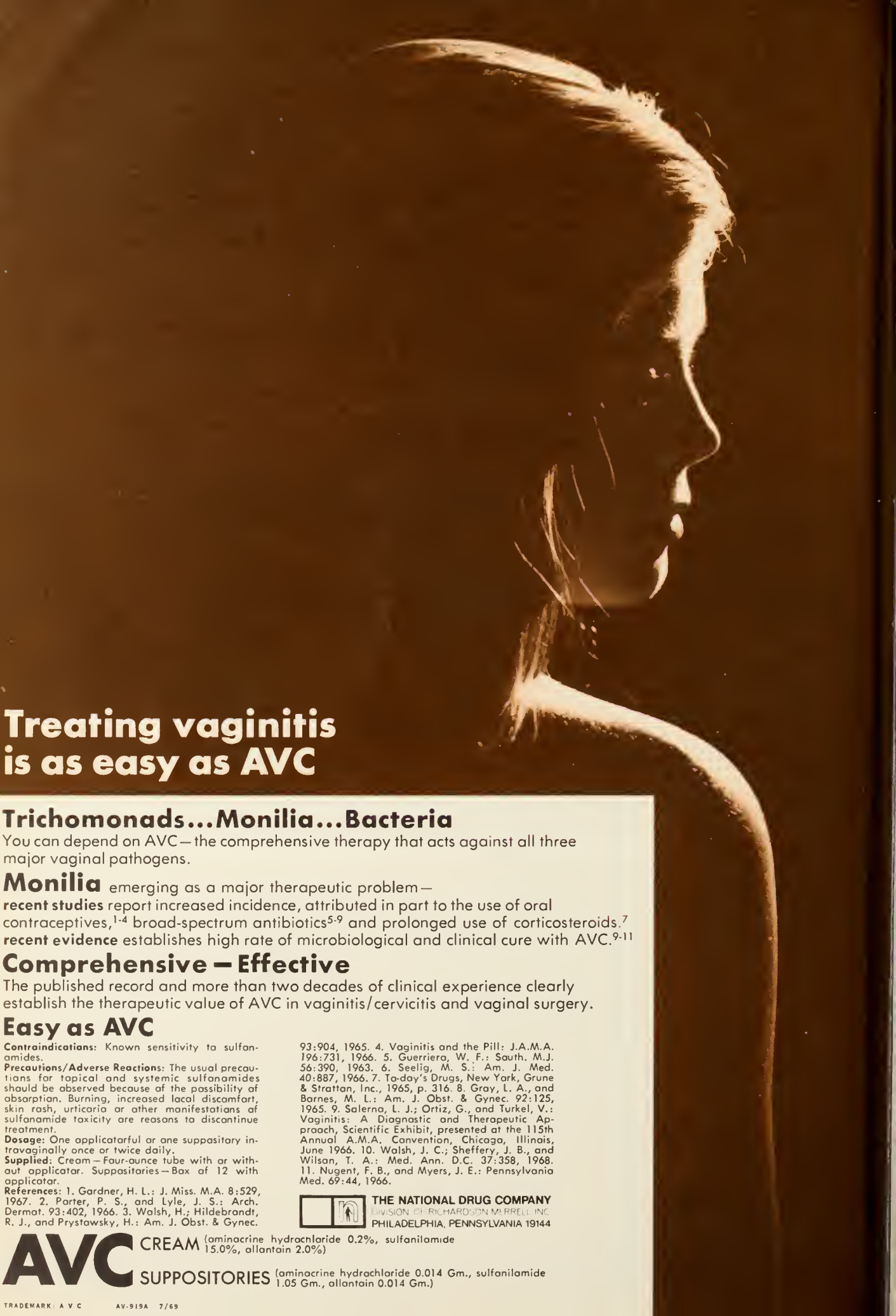
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with orthritis, diabetes, varicose veins, thrambophlebitis, arterlosclerosis ond stotic foot deformities. **Contraindications:** QUINAMM is contralndicoted in pregnancy becouse of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinol cromps In some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, ond gastrointestinal disturbance. Discontinue use if ringing in the eors, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosoge moy be increosed to one tablet fallowing the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 ond 500 toblets.

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Quinamm™
(quinine sulfote 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfanamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfanamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfanamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

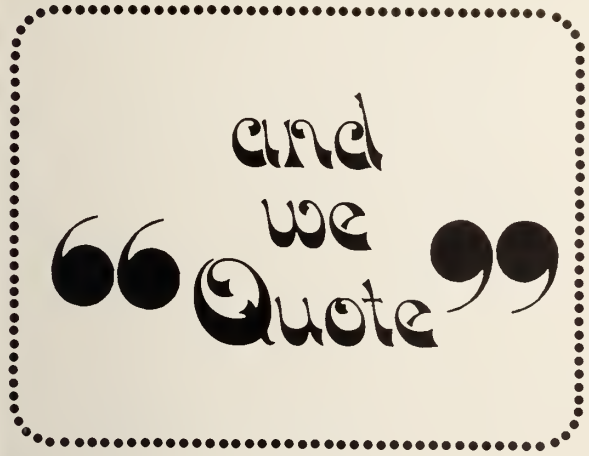
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AV-919A 7/69



Future Practice and the Osteopath

"Accepting then this statement (AMA President) at its face value, what is the significance of it to the young graduate? Does it signify that his education at this point is substandard? Does it imply or does it in any sense guarantee that at the completion of internship and/or residency that he will be an equal with doctors of medicine? If so, is it intended that by some means his D.O. Degree will be used as the basis for the issuing of an M.D. Degree? Or does it mean that his D.O. Degree, which is entirely valid and a respectable earned degree, will continue to differentiate him in actual practice from doctors of medicine?" — James O. Watson, D.O., in the *Buckeye Osteopathic Physician*

Please Allow Me to Select My Own Physician

"Most of us, I feel certain, have had experiences that sharply forced us back to reality (from new theories for the delivery of health care). A few days ago a knowledgeable engineer sat opposite to me in my consultation room when I remarked that one of our committees was examining alternative methods for the delivery of health care. His reply was an unequivocally succint: 'I don't know what you are up to, doctor, but please allow me to select my own physician.' " — Edward A. Burkhardt, M.D., President, Medical Society of the County of New York

Medicine and Religion — Cooperative Care of the Patient

"I believe a clergyman has the moral right to expect of a physician the necessary time and courtesy to discuss cooperative care of a sick patient. He should expect to be given enough of the medical details of the problem to help him counsel the patient and family effectively. In short, he should be made to feel that he is an equal partner.

"A physician has the right to expect of the clergyman an equal frankness in discussion of the spiritual factors involved. For instance, the question whether the patient has any spiritual faith whatever, whether he believes in a vengeful or a forgiving God, whether he thinks of illness and death as punishment for past sin — are all important factors in the outcome of serious illness. The physician also has the right to be assured that nothing will be suggested by a clergyman which would weaken confidence in medical treatment." — *Philadelphia Medicine*

For men, by their Example Pattern Out . . .

"One wonders if this drug epidemic is not actually another face of middle class America's passion for alcohol and other medication anyway. So many of us drink on almost every social occasion and it is hard to persuade the son or daughter that the use of ethyl alcohol for relaxation or flight from reality is commendable while resort to pot for the same purposes is evil." — *Journal of the Medical Society of New Jersey*

Some Avowed Sympathy for Student Protest

"A period of tumult marred this academic year. No part of the University escaped the psychological shock waves which followed the assault in April by a small group of militant students and non-students calling themselves the Students for a Democratic Society. - - -

"The demands of the SDS did not impinge specifically on any of the recent activities or future plans of the School of Public Health. Our students, many of whom expect soon to be members of faculties themselves, viewed the events in Cambridge with great interest, and some avowed sympathy for the general student movement of protest against the injustices of contemporary society. Our students by and large felt the urge to do something constructive, and they focussed their attention on the decision-making processes of this School and of the University as a whole. They conducted several forums to which they invited employees, staff, and faculty. They compiled and distributed information about the organization and operation of the school. They

offered several valuable suggestions for improving the relations between faculty, staff, and students, some of which were promptly adopted. From the tone of the questions which were raised in the forums, it was evident that several, perhaps many, of the individuals associated with the school wish to have greater involvement in the affairs of community agencies. The forums are expected to be continued next year." — Dean's Report, Harvard University School of Public Health

Who Would Be Free Must First His Brother Free

"Like doctors, these journalists are dedicated to their profession, work long hours, are aware of their responsibilities, and proudly practice an historical code of ethics. When their mode of operation was criticized, like us, they responded with an immediate defense of themselves and their work, assumed the stance of the persecuted, over-reacted to the charges, and accused the government of attempting to take away their freedoms and even to take over the industry. Of course they had much better audience exposure for their response than we did.

"Like the doctors, in retrospect, they are missing the over-view; they are overlooking the big picture. They do not appreciate the significance of the majority of public opinion, which is difficult to measure in strength because of political overtones. Obviously *the people* are trying to say something." — *Rocky Mountain Medical Journal*

Psychotic Behavior? We Can Get It for You Wholesale

"If American medicine is dealing adequately with the manifold domestic diseases of this nation, it is a well kept secret. Although they occupy positions of prestige and influence in the modern social scaffolding, many doctors today seem unaware of or unresponsive to the state of their milieu. Medical students are rapidly becoming aware of grave medical shortcomings in many areas of our hyper-inflated society, and for good reason. It is our contemporaries who are taking drugs, asking for abortions, trying to free a race of social and economic slaves, and dying in Vietnam. Any physician would recognize the psychotic behavior of the patient who willingly ingests his own excrement, and attempt to treat him; but few seem to be reacting to this behavior on a mass scale." — Medical Students Kenneth Embry and John Rice in the *Bulletin of the Jefferson County Medical Society*, Louisville, Ky.

Brief Summary of Prescribing Information— 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angütis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®
hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

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The antihypertensive therapy that is easy to live with.*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

Easy-to-live-with control. Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

*Salutensin is usually well-tolerated (however, serious side effects can occur; see adjacent column for brief summary of prescribing information).

Easy-to-live with dosage. Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.





With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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WALKER, CORP & CO., INC.
Syracuse, New York 13201

A Unique Book for Stamp Collectors

The philatelist whose interests turn to the medical field will find fascination in a new book published by the American Medical Association under the title *Medicine and Stamps.*

With descriptions and illustrations of stamps listed alphabetically according to the person immortalized, it begins with Angel Arturo Aballi, Cuban physician fighter for the rights of children and medicine against hostile political regimes, and ends with Lazarus Ludwig Zamenhof, Russian ophthalmologist and developer of Esperanto, the universal language. In between are over 150 medical greats immortalized on stamps from 53 different countries.

All of the stamps are identified by number from *Scott's Standard Postage Stamp Catalogue.*

Background of the book's development is interesting. It all started in Miami in 1960 when the late John A. Mirt staged a postage stamp exhibit entitled "Medical Pathfinders on Stamps" at an AMA meeting. Interest grew until more than 200 biographical vignettes appeared in *JAMA* over a period of nine years.

The book is a compilation of these articles, edited by two physician-philatelists of the Mayo Clinic. It may be ordered from the AMA, 535 N. Dearborn Street, Chicago, Illinois 60610 for $4.00.

Procedural Terminology Manual Announced

Current Procedural Terminology (CPT) is a dictionary of terms and codes for the naming and designation of diagnostic and therapeutic procedures in surgery, medicine, and the specialties. The system of CPT follows the basic concepts and purposes of the Committee on Health Care Financing, American Medical Association, namely the presentation of a system to simplify and standardize terminology and coding for clinical reporting.

This is the second edition. The format is like the first in its alphabetical and numerical listing of procedures and the use of special headings and sections. It has made a few additions and deletions. Notable among these: the introduction of a key-work-in-context index for the listing of surgical terms by organ or part; a special listing of procedures related to internal medicine; and the addition of 60-70 percent more procedures than listed in the first edition.

The 368-page book may be ordered from the American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610, at $2.00.

MDs in the News

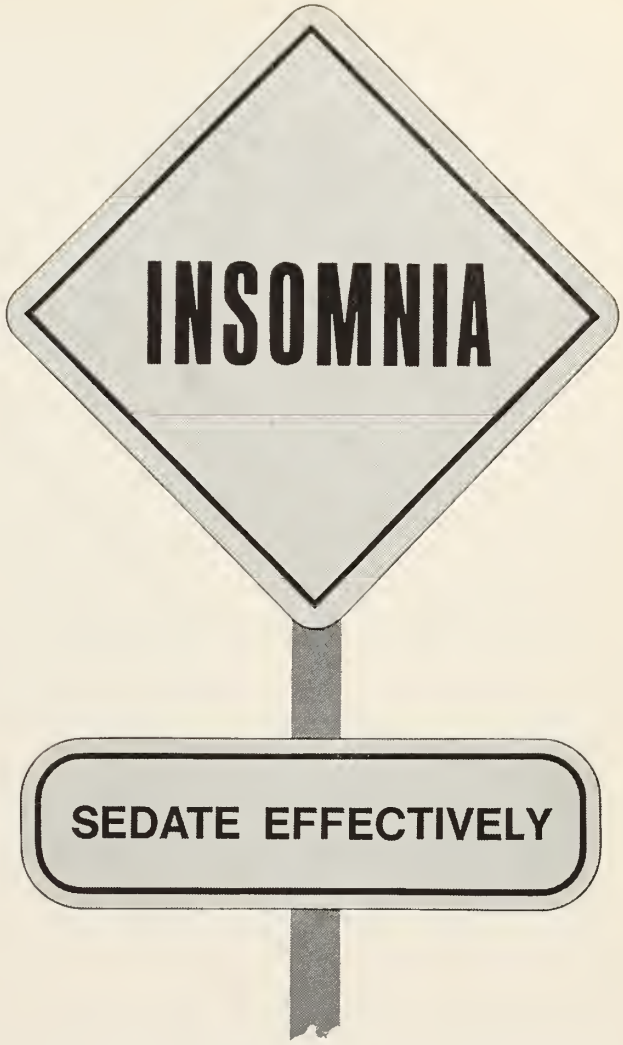
Dr. Effie O. Ellis, former director of maternal and child health for the Ohio Department of Health, with headquarters in Columbus, has been chosen by the American Academy of Achievement to receive the Golden Plate Award during the ninth annual Salute to Excellence weekend, June 25-27, Dallas. Dr. Ellis is now special assistant for health services of the American Medical Association, with headquarters in Chicago.

Dr. Carl E. Wasmuth, of Cleveland, has been named chairman of the American Medical Association's Committee on Medicolegal Problems. He has previously served as a member of the committee. An attorney as well as a physician, he is a member of the American Bar Association and the AMA. Dr. Wasmuth is chairman of the Board of Governors of the Cleveland Clinic and chairman of the Board of Trustees of the Cleveland Marshall College of Law.

"The Gloved Hands," a piece of sculpture by Robert McGuire, was dedicated recently in the new Cincinnati General Hospital, in memory of Dr. H. Thomas Fox, who died about a year ago of a disease contracted in Vietnam.

Ohio Radiologists Awarded Fellowships

The following Ohio physicians received the Fellowship degree of the American College of Radiology at the recent annual meeting of the college in Dallas, Texas: Dr. Benjamin Kaufman, Shaker Heights, Ohio State University College of Medicine, 1952; Dr. Archie Fine, Cincinnati, University of Toronto Medical School, 1931; Dr. Dana R. Schmidt, Worthington, Duke University School of Medicine, 1949; Dr. Atis K. Freimanis, Columbus, University of Hamburg, Germany, Faculty of Medicine, 1951; and Dr. Jerome F. Wiot, Cincinnati, University of Cincinnati College of Medicine, 1953.



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Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

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Research Protocol

Pathophysiology of Intractable Pain and Treatment with Nonsurgical Technics

A combined clinical and basic research study is presently under way to gain some insight into the mechanisms of such pain, to evaluate several nonsurgical methods of treatment of intractable pain, and to determine selection of patients for such procedures.

There are several methods of pain treatment that are used in this investigation, primarily percutaneous cervical cordotomy. This is a procedure in which a needle electrode is passed into the spinal cord in the cervical area under x-ray guidance, and the pain pathways are interrupted with a radio frequency current. This is rapidly becoming a well-accepted clinical procedure and has been performed over 300 times in this project alone. The opportunity for satisfactory alleviation of intractable pain approaches that of open surgical cordotomy, and the incidence of permanent side-effects appears to be somewhat less.

A technic has been devised for making a lesion of the lower cervical area in order to avoid the respiratory complications, which sometimes accompany the production of lesions in the upper cervical area. The respiratory patterns after lesions in these two areas will be compared.

Efforts will be made to analyze the results of this procedure, and to compare it with the success of other procedures. Patients will be categorized in hopes of permitting a more detailed evaluation of candidates for percutaneous cervical cordotomy.

Access to this group of patients will permit a detailed study of the sensory modalities affected by this type of cordotomy. Recordings of spinal cord activity and results of spinal cord stimulation afford a better insight into the mechanism of pain sensation.

In addition, other methods of treatment of pain will be investigated, and their effectiveness will be compared with that of cordotomy. These other methods include various phenol and alcohol blocks.

Those patients who are not candidates for the above procedures for treatment of intractable pain may be eligible for stereotaxic surgical treatment. This involves the use of a stereotaxic guiding device to implant an electrode into those areas of the thalamus and surrounding structures which are concerned with the perception of pain. Interruption of these pathways can frequently be used to treat intractable pain.

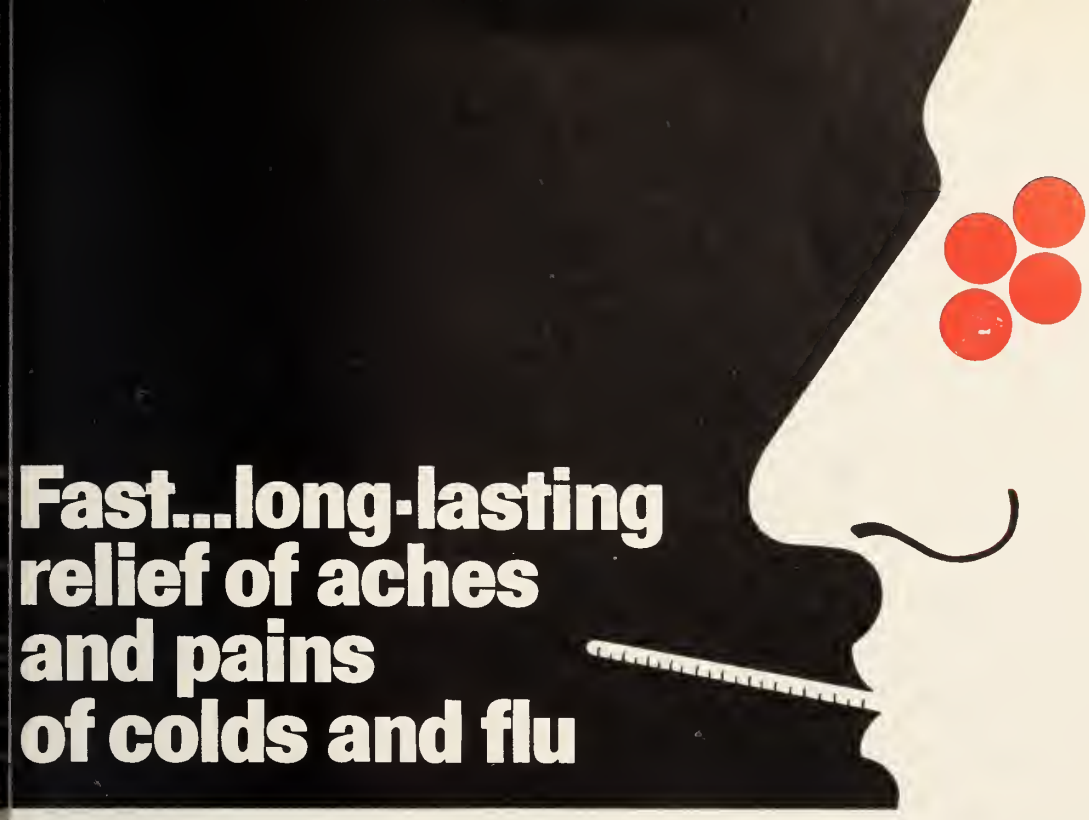
Selection of Patients

Patients with intractable pain secondary to benign or malignant organic disease will be eligible for this study. This includes patients with pain about the face or head, as well as pain involving the body or extremities. Failure of a previous pain-relieving procedure would not disqualify patients from this study, nor would addiction to narcotics.

It is to be stressed that the decision as to the most appropriate method of treatment of intractable pain will be based purely on clinical judgment. No patient will be subjected to a procedure which is not clinically indicated, and no patient will be deprived of the most appropriate pain-relieving procedure for purposes of this investigation.

It is also to be understood that not all patients who are evaluated will be candidates for such pain-relieving procedures, but it is hoped that many patients with organic disease who would not ordinarily be considered for pain-relieving procedures might be treatable with some of these newer technics.

Cooperation is also sought for the acquisition of post-mortem brain and spinal cord specimens of patients who have been included in the study and later die of their disease at other hospitals —Philip L. Gildenberg, M.D., Cleveland Clinic, Cleveland.



Fast...long-lasting relief of aches and pains of colds and flu

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Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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MEASURIN®
TIMED-RELEASE ASPIRIN

ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.

Cincinnati Booklet Promotes Clean Air Concept

The Academy Journal Publishing Company, cooperating with the Academy of Medicine of Cincinnati, has published a booklet entitled "The Cleaner Air Commitment."

Dr. Robert S. Heidt, president of the Academy, stated that this publication marks a milestone in accomplishing what the Academy has recommended for some 12 years. It is a discussion of air cleansing methods and is an effort to get industry to install mechanical devices that will keep the air cleaner. The contents were edited by Professor Nathan Gilbert, chemical engineer on the faculty of the University of Cincinnati.

A copy of the illustrated monograph may be obtained for $1.00 from the Air Pollution Control League of Greater Cincinnati, 18 E. Fourth Street, Cincinnati 45202.

Pediatric Symposium in Louisville

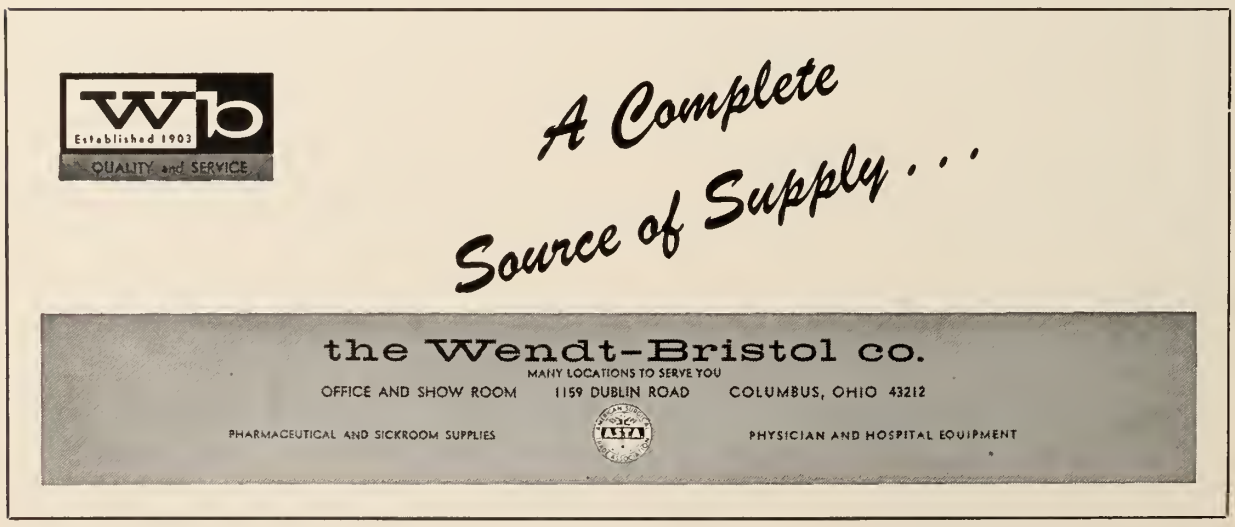
The Department of Pediatrics, University of Louisville School of Medicine, will present its Fourth Annual Symposium on the Newborn, entitled "Metabolic Problems in the Newborn," November 5-6. Guest speakers as well as members of the local faculty will present the program. For details write: Billy F. Andrews, M.D., Professor and Chairman, Department of Pediatrics, 226 E. Chestnut Street, Louisville, Ky. 40202.

What To Write For

Helping Your Child Speak Correctly — This is one of a series of pamphlets published "to develop new techniques to educate the American public on vital economic and social problems." A copy may be obtained for 25 cents, and will contain instructions for ordering in quantity. It is Pamphlet No. 445 and may be ordered from Public Affairs Pamphlets, 381 Park Avenue, South, New York, N. Y. 10016.

A Study of Air Conditioning, Heating, and Ventilating Design for Veterans Administration Hospital Kitchens and Laundries. One of the most plaguing problems over the years has been the build up of heat and humidity in hospital kitchens and laundries. The report suggests standards and provides sketches, details and comparative costs for alternative systems and heat-saving devices. $2.50 plus postage from the Veterans Administration, Office of Construction (08C), 810 Vermont Ave., N. W., Washington, D. C. 20420.

Transfers for Patients with Acute and Chronic Conditions — An illustrated booklet describing basic procedures for assisting and teaching patients to perform sitting and standing transfers, equipment to be used, etc. The Kenny Rehabilitation Institute, American Rehabilitation Foundation, 1800 Chicago Avenue, So., Minneapolis, Minn. 54404; price $1.65.



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All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

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MUDRANE GG
During pregnancy or when K.I. is contraindicated or not tolerated

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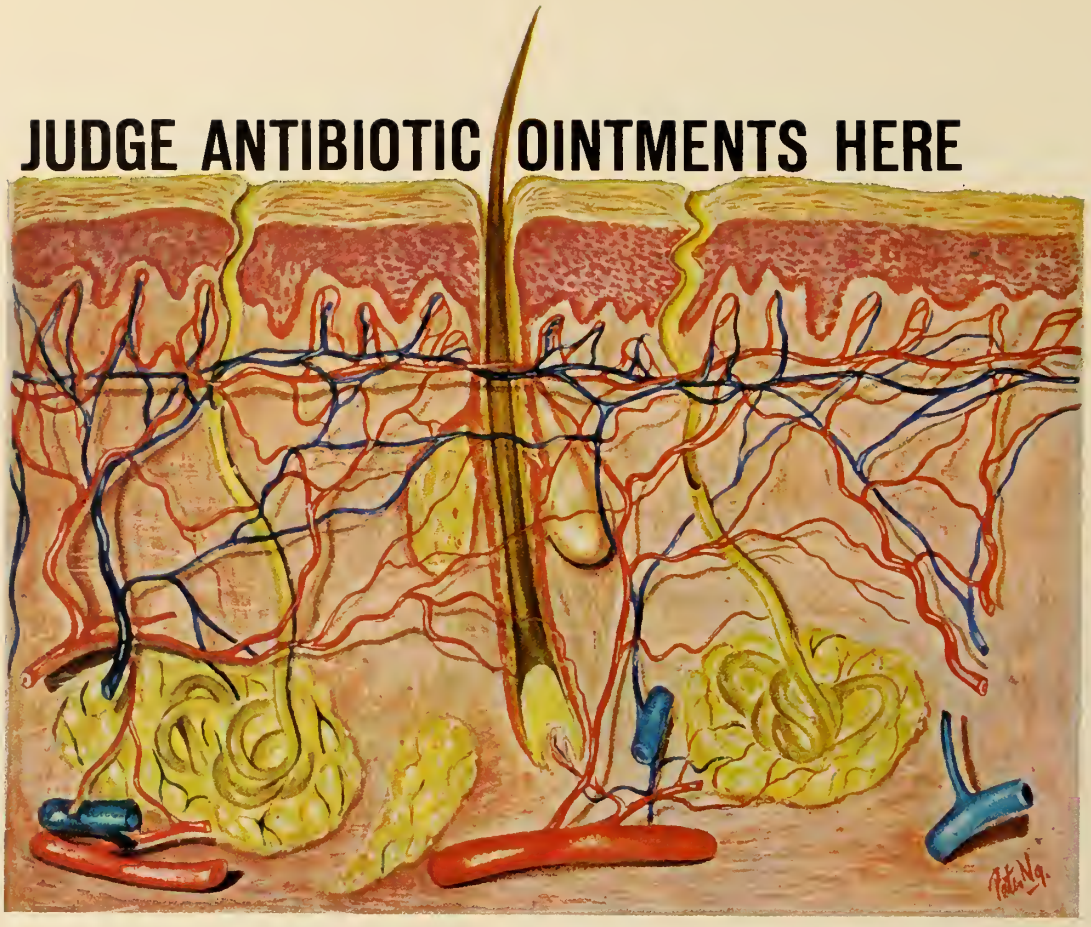
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Arrhythmias in Acute Myocardial Infarction

Assessment of Incidence Among 250 Patients Treated in a Coronary Care Unit

EUGENE MASCARENHAS, M.D., AND HENRY A. ZIMMERMAN, M.D.

THE IMMENSE GROWTH of coronary care units has produced a voluminous outpouring of data[1-11] regarding the incidence, natural course, significance and prognosis of arrhythmias occurring in accute myocardial infarction. A critical assessment of these results shows many discrepancies. The incidence of arrythmias is seen to vary from 72 percent to 95 percent.[3] Certain specific arrhythmias have been considered benign and transient by some authors and more sinister by others. Results of successful resuscitation from cardiac arrest vary from 15 percent to 40 percent and overall mortality from 14 percent to 36 percent.

It is apparent that these discrepancies are a result of the concomitant existence of a number of variable factors present in the patient population. Certain factors like increasing age,[1,4,5,8] the female sex,[12] multiplicity of arrhythmias,[1,10] clinical severity of infarction,[1,4,5,8,10,11] and preexisting heart disease [1,5,8] have been shown to affect adversely the prognosis of patients with acute myocardial infarction.

It is imperative that, for intelligent therapy and resuscitation, arrhythmias should be viewed in the light of these variables. The purpose of this paper is to report the incidence of arrhythmias in high risk groups and to discuss their prognostic implications.

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Materials and Methods

Selection of patients.—The case records of 250 consecutive patients with acute myocardial infarction admitted to the eight-bed coronary care unit of St. Vincents Charity Hospital, Cleveland, Ohio between August, 1965 and February, 1968 are reviewed.

Diagnosis was based on the clinical history associated with development of diagnostic Q waves or serially evolving ST segment and T wave abnormalities on the initial electrocardiographs with characteristic changes in serum glutamic

oxaloacetic transaminase and lactic dehydrogenase levels in blood samples.

No selection was placed on age, sex, clinical severity of infarction, presence or absence of arrhythmias, preexisting heart disease, or associated medical illnesses. Two patients were included more than once, as they required readmission for another acute episode of myocardial infarction.

Necropsy was performed in 42 percent of the fatal cases and confirmed the diagnosis of transmural myocardial infarction in all of these.

Method.—After recording a standard 12-lead electrocardiogram, electrocardiographic monitoring was immediately instituted. This consisted of oscilloscope placed both in the patient's room and at the central nursing station. The central control center is equipped with a rate meter which registers the ventricular rate, a visual and audible alarm system which activates a direct writing recorder and is provided with a 60-second delay tape. Control permits the selection of cardiac rates above or below which one wishes the alarm to operate. Thus records are obtained 60 seconds before a violation occurs. A note is made of all arrhythmias observed, and the tracings are kept as a permanent record. After the period of monitoring, which ranged from 40 minutes to three weeks (average: five days), patients were transferred to an adjoining cardiac convalescent floor, which provided skilled nursing personnel, immediate resuscitative facilities, and speedy transfer to the coronary care unit in the face of sudden arrhythmias or cardiac deterioration. Patients were generally discharged from the hospital three to five weeks after admission.

Staffing.—The patients in this study were under the care of different attending physicians. The Department of Cardiology provides constant instructions to the nurses and resident physicians in the management of patients with acute myocardial infarction. Frequently revised and updated guidelines in the management of arrhythmias are displayed at the nursing station. Residents in Cardiology are allotted to the unit and provided a room within its confines, thus being immediately available at all hours of the day and night.

Management.—During the period covered by this review, a wide range of therapy has been used. This is briefly outlined as follows:

Patients were advised in the pattern of management and reassured to allay anxiety. They were allowed to adopt a position of comfort in bed and were provided a light diet while in the coronary care unit. In the absence of shock or hypotension, a bedside commode was permitted. Oxygen by nasal mask or cannula was administered throughout their stay in the unit. Analgesia was obtained with morphine sulphate or meperidine (intramuscularly). Sedation was achieved with oral barbiturates or chlordiazepoxide. Anticoagulants, either heparin or oral agents, were used in 86 percent of patients. Obvious cardiac failure was treated with digitalis and diuretics. Shock was treated with metaraminol, isoproterenol, noradrenaline, or steroids. Supraventricular arrhythmias with rapid rate were treated with intravenous Lanatoside-C or digoxin. If satisfactory control of ventricular rhythm was not achieved, synchronized countershock[13] was employed.

Patients with frequent ventricular ectopic beats received a variety of therapy during the period of review. Initially procainamide, orally or intramuscularly, was the drug of choice, but more recently lidocaine, 50 mg. intravenously, followed by 1 to 5 mg. per minute as an intravenous drip was employed to control ectopic beats. Quinidine and propranalol were used in a few instances. Ventricular tachycardia was treated with 500 to 1,000 mg. procainamide intravenously and, if sustained, with direct current (D.C.) countershock.[13] Sinus bradycardia or atrioventricular (A.V.) block, when associated with a slow ventricular rate, were treated with atropine or isoproterenol intravenously to increase the heart rate. Adrenal cortical steroids[14] were employed in incomplete and complete heart block. Internal cardiac pacing was not employed.

Cardiac arrest was treated with immediate external cardiac massage[15] and emergency ventilation. A venous cut-down was employed for administration of sodium bicarbonate and other medications. Ventricular fibrillation was dealt with by direct current countershock[13] at 400 watts per second, followed by procainamide, intramuscularly, lidocaine, intravenously, or propranalol to suppress further ectopic activity. When arrest was due to ventricular asystole, isoproterenol, intravenously, and steroids were employed. Resuscitative measures were maintained until it was found impossible to maintain effective circulation.

Terminology.—The classification of arrhythmias,[8] which relates the disorders of the heart beat to the underlying clinical situation instead of the anatomic site, has been found most practical and is adopted in this study. Arrhythmias accordingly have been categorized into four types: those relating to electrical failure, pump failure, potential electrical instability, and electrical instability (Table 4).

When a single arrhythmia occurred in a patient, it was referred to as "single." If two or more arrhythmias occurred in the same patient, they were referred to as "multiple."

On the basis of initial clinical examination, after chest pain was adequately relieved, patients were divided into three categories of clinical se-

verity: mild, severe,[16] and cardiogenic shock.[17] Mild cases had no evidence of cardiac failure or hypotension. Severe cases were those with a systolic arterial pressure below 100 mm. Hg. and/or the presence of left ventricular failure. Shock was considered present in patients with a systolic arterial pressure below 80 mm. Hg., cyanosis, pallor, sweating, altered sensorium, oliguria, and failure to improve within 30 minutes of relief of pain and administration of oxygen.

Results

Mortality.—Assessment of mortality was made at the time of hospital discharge. Forty-three patients died (17.2 percent). Of these, 33 were men and ten women, a mortality rate of 17.4 percent and 16.9 percent respectively. The mortality in various decades of age is shown in Table 1. Mortality rate is seen to increase with advancing age. The average age of all patients was 58 years. The patients who died had an average age of 62 years. Mortality rate increased with increasing clinical severity of infarction (Table 5) and in patients with preexisting heart disease (Table 6). Patients with multiple arrythmias also had a higher mortality rate (46 percent) than those with single arrhythmias (5 percent).

Table 1. Age, Sex, and Mortality Rate in 250 Patients with Myocardial Infarction

Age Group	Men	Women	No. of Deaths
30-39	5	0	0 (0.0%)
40-49	42 (5)	1	5 (11.6%)
50-59	68 (9)	19 (2)	11 (12.6%)
60-69	51 (11)	19 (3)	14 (20.0%)
70-79	21 (7)	17 (4)	11 (28.9%)
80-89	3 (1)	4 (1)	2 (28.5%)
Total	190	60	43
Average Age	57 yrs.	66 yrs.	63 yrs.

(Numbers in parenthesis represent dead patients.)

The initial 24 hours of hospitalization were the most critical, accounting for 30 percent of the deaths. By the end of the first week, 71 percent of the deaths had occurred.

The mechanism of death in the unit and the wards is presented in Table 2. In two patients dying on the convalescent floor, the terminal mechanism could not be definitely ascertained. Associated medical illnesses were contributory to the fatal outcome in three patients. These deaths were due to pneumonia, chronic renal failure, and subacute bacterial endocarditis.

Time Delay in Admission.—Table 3 shows the time delay between onset of symptoms and admission to the coronary care unit. Forty-three percent of the 250 cases were admitted within four hours of symptoms, the mortality rate being 22 percent in these patients. The delay exceeded 12 hours in 27 percent of the patients. In two instances, although serial electrocardiograms and enzymes confirmed myocardial infarction, the precise time of infarction could not be ascertained.

Table 2. Causes of Death

	Cause	In Unit	In Ward
Arrhythmia	Ventricular fibrillation	4	1
	Ventricular asystole	2	0
Pump failure	Shock	13	0
	Pulmonary edema	4	0
	Heart failure	7	3
	Myocardial rupture	3	1
	Cause unknown	0	2
Complicating medical illnesses	Pneumonia	—	1
	Chronic renal failure	—	1
	Subacute bacterial endocarditis	—	1

Incidence of Arrhythmias.—During the monitoring period, 86 percent of the patients developed arrhythmias. The incidence of various arrhythmias, along with the mortality in each group, is shown in Table 4. In the past, much emphasis has been placed on description of specific arrhythmias. The results of this study show that a single arrhythmia occurred in less than one third of patients. Patients with single arrhythmias had a more favorable prognosis (mortality rate 5 percent). Patients with multiple arrhythmias had a mortality rate of 46 percent. Serious arrhythmias, such as ventricular fibrillation, ventricular tachycardia, atrial fibrillation, and complete heart block (91 percent) were invariably associated with other disorders of rhythm or conduction. The combination of supraventricular arrhythmia and infranodal arrhythmia was found particularly sinister. Six patients with atrial fibrillation developed ventricular fibrillation, which proved fatal in all of them. These patients also had significant pump failure, which may have contributed to the failure in resuscitation. In contrast, the eight patients successfully resuscitated from ventricular fibrillation had no concomitant supraventricular arrhythmia or conduction disturbance.

An association of bundle branch block with a supraventricular arrhythmia carried a mortality

Table 3. Time Delay Between Onset of Symptoms and Admission to Unit

Time (Hours)	Number
0- 4	108
5-12	74
13-24	47
25-48	17
Over 48	2
Undetermined	2

of 13 percent, but when associated with an infranodal arrhythmia, the mortality rate increased to 53 percent. Uninterrupted sinus rhythm or sinus rhythm with only extra systoles had a very favorable prognosis. The only death occurring in this group was found, at autopsy, to be due to myocardial rupture.

Arrhythmias and Age.—Figure 1 shows that arrhythmias of electrical instability were the most frequent, occurring in 55 percent to 65 percent of patients. Arrhythmias of potentional electrical instability and ventricular fibrillation had a lesser incidence, occurring in no percent to 20 percent of patients. None of these was related to age. In contrast, arrhythmias of pump failure increased with advancing years from 20 percent in the fourth decade to 100 percent in the ninth decade. Four patients developed unexpected ventricular asystole; however, the episode bore no relationship to age, the average age being 59 years.

The greater mortality associated with increasing years (Table 1) would lead one to expect a rising fatality rate in the four groups of arrhythmias with advancing age. However, this was not seen to be so. Figure 2 shows that the mortality rate associated with arrhythmias of pump failure and ventricular fibrillation was uninfluenced by age. Approximately one third of the patients with arrhythmias of pump failure died in each decade. Successful resuscitation from ventricular fibrillation with hospital survival was achieved at all ages, ranging from 34 to 80 years. The unequal distribution of patients, with resulting paucity of numbers in the fourth and ninth decades, permits no valid conclusions to be drawn at these ages.

Arrhymias and Sex.—The ratio of male to female patients in this series was 3.2:1. The ratio was maintained among the patients who died. It was found that women had a greater incidence of arrhythmias of pump failure. This was due to the fact that they developed myocardial infarctions at a later age (average age: 65 years) than males (average age: 56 years). Figure 1 shows that the incidence of arrhythmias of pump failure increases with age.

Julian, et al[3] have observed ventricular fibrillation and ventricular tachycardia to predominate in men and bundle branch block to occur in women. No such association was seen in this series. Prognosis of arrhythmias was similarly unrelated to the sex of the patient.

Arrhythmias and Clinical Severity of Infarction.—On the basis of initial clinical examination, patients were divided into three groups of clinical severity.

Mild cases had no evidence of cardiac failure or hypotension. Severe cases were those with a systolic arterial pressure below 100 mm. Hg. and/or the presence of left ventricular failure.

TABLE 4. Incidence and Mortality of Arrhythmias in 250 Consecutive Patients with Acute Myocardial Infarction

Category of Arrhythmias	No. of Patients	Mortality Rate
Electrical failure		
Ventricular fibrillation	25 (10%)	17 (68%)
Ventricular asystole	4 (2%)	4 (100%)
Pump failure		
Sinus tachycardia	75 (30%)	27 (36%)
Atrial extrasystoles	41 (16%)	5 (12%)
Atrial or nodal tachycardia	12 (5%)	3 (25%)
Atrial flutter	10 (4%)	2 (20%)
Atrial fibrillation	30 (12%)	10 (33%)
Potential electrical instability		
Sinus bradycardia	39 (16%)	2 (5%)
Nodal premature beats	42 (17%)	4 (10%)
Heart block 1°	22 (9%)	3 (14%)
2°	17 (7%)	3 (18%)
3°	9 (4%)	5 (56%)
Nodal rhythm	10 (4%)	4 (30%)
Electrical instability		
Ventricular extrasystoles		
Over 6 per min.	54 (22%)	18 (15%)
Under 6 per min.	110 (44%)	15 (14%)
Ventricular tachycardia	32 (13%)	10 (31%)

TABLE 5. Morbidity and Mortality Related to Clinical Severity in 250 Patients with Myocardial Infarction

	Mild	Severe	Shock
Distribution of patients	151 (60%)	86 (35%)	13 (5%)
Incidence of arrhythmias	116 (77%)	86 (100%)	13 (100%)
a. single	51 (34%)	14 (16%)	1 (8%)
b. multiple	65 (43%)	72 (84%)	12 (92%)
c. electrical instability	91 (60%)	60 (65%)	10 (77%)
d. potential electrical instability	18 (12%)	14 (16%)	2 (15%)
e. pump failure	16 (11%)	68 (79%)	11 (85%)
f. ventricular fibrillation	6 (4%)	15 (17%)	4 (31%)
g. asystole	1 (0.6%)	14 (19%)	9 (69%)
Successful resuscitation from ventricular fibrillation	6 (100%)	2 (14%)	0 (0%)
Hospital mortality	1 (0.6%)	29 (34%)	13 (100%)

TABLE 6. Influence of Previous Heart Disease on Mortality and Arrhythmias of Pump Failure

Past History	No. of Cases	Arrhythmias of Pump Failure: Mortality Rate	No. Cases	Mortality Rate
Angina pectoris				
Present	69	28%	25	64%
Absent	181	13%	68	25%
Myocardial infarction				
Present	61	26%	26	50%
Absent	189	14%	67	30%
Heart failure				
Present	33	45%	28	50%
Absent	217	13%	65	29%

Shock was considered present in patients with a systolic arterial pressure below 80 mm. Hg., cyanosis, pallor, sweating, altered sensorium, oliguria, and failure to improve within 30 minutes of relief of pain and administration of oxygen. The morbidity and mortality of these three groups is shown in Table 5. The incidence of all four types of arrhythmias increased with increasing severity of infarction.

The response of ventricular fibrillation to resuscitative measures was greatly influenced by

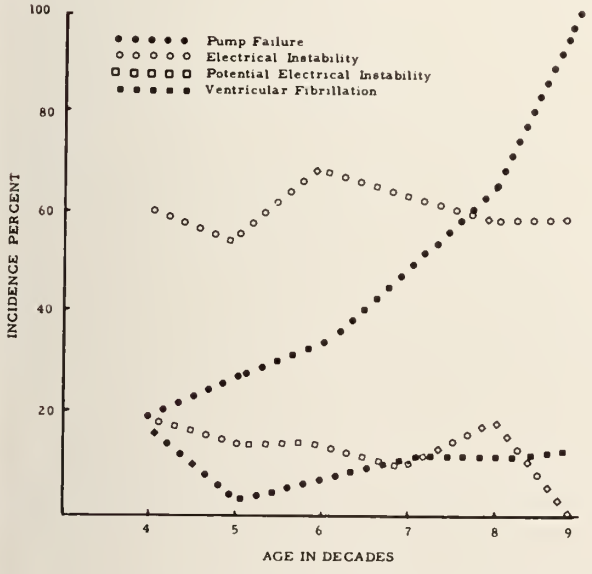


FIG. 1. Incidence of arrhythmias in relation to age.

the severity of myocardial infarction. Successful resuscitation with hospital survival was achieved in all six patients with mild infarctions. In 15 patients with severe infarctions, successful resuscitation from ventricular fibrillation was possible in only four patients. Two of these, however, died of a fatal recurrence within 24 hours. The remaining two patients had an uneventful course until hospital discharge. Ventricular fibrillation was fatal in all four patients with cardiogenic shock. In each of these, the arrhythmia appeared agonally.

Recurrent ventricular fibrillation was observed in three patients with mild infarction and all were successfully resuscitated. Two patients with severe infarction succumbed to their recurrent episode. All episodes of recurrence occurred within 24 hours of the first episode. Figure 3 shows the time occurrence of ventricular fibrillation in the three grades of clinical severity. Ventricular fibrillation occurred within 24 hours of initial symptoms in five of six patients with mild infarction. In the remaining one patient, it followed an episode of severe chest pain on the 20th hospital day. Resuscitative efforts were successful and the patient was discharged alive. Serial electrocardiograms and enzyme studies following recovery from cardiac arrest documented a fresh episode of myocardial infarction.

In severe cases, ventricular fibrillation occurred relatively late (second to 12th day) with a maximum incidence between the fifth and tenth hospital day. The two patients in this group who were successfully resuscitated and achieved hospital survival developed ventricular fibrillation on the fifth and sixth postinfarction day, respectively.

Ventricular fibrillation occurred as an agonal event in four patients with cardiogenic shock, death occurring within five days of admission in all of these patients. Unexpected ventricular asystole developed in one patient with mild infarction and in three patients with severe infarctions, while in the coronary care unit. Resuscitative efforts were uniformally unrewarding. A necropsy obtained in two of these patients revealed myocardial rupture in both of them.

Arrhythmias of pump failure were found to be relatively transient and benign in mild cases and were always persistent in the shock group. In the severe group, atrial fibrillation developed in 16 patients. In half of these, reversion to sinus rhythm did not occur. Six of them died with terminal ventricular fibrillation between the sixth and 16th hospital days. The clinical characteristics of these six patients showed them to be elderly (average age 68 years) with preexisting coronary artery disease (average duration five years) and significant cardiomegaly. Poor control of ventricular rate and relatively resistant cardiac failure was a common feature. It appears that death in these six patients was due to lack of myocardial reserve rather than to the arrhythmias.

Prognosis in arrhythmias of potential electrical instability was related to the clinical severity of infarction. Sinus bradycardia and incomplete heart block were benign and transient in 20 patients with mild infarction. None of these progressed to complete heart block. Among 31 severe cases, progression to complete heart block was observed in eight patients. Sudden development of complete heart block as a terminal rhythm in cases of cardiogenic shock has been noted by others and was observed in one patient.

Altogether, nine patients had complete heart block. Eight of these had severe infarctions and one was in shock. A satisfactory ventricular rate was obtained in six of the eight severe cases by pharmacologic means. Both patients, in whom a satisfactory ventricular rate was not achieved, died. An autopsy disclosed irreversible anatomic

lesions in both. In one of them, myocardial rupture was seen. The other patient was found to have gross cardiomegaly, rheumatic mitral valve incompetence, and an extensive posterior wall myocardial infarction. Two of the six patients with severe infarction, in whom a satisfactory ventricular rate was achieved, died. One died of myocardial rupture and the other patient developed sudden ventricular asystole after having been in normal sinus rhythm for almost 40 hours. An autopsy was not obtained. The patient in cardiogenic shock who developed complete heart block also died and an autopsy was not obtained.

Ventricular ectopic beats and ventricular tachycardia were, as a rule, relatively transient, benign, and self-limiting in patients with mild infarction. In severe cases, they were more frequent and persistent. The R on T phenomenon,[18] with subsequent development of ventricular fibrillation, was observed in only one instance. Ventricular tachycardia progressed to ventricular fibrillation in nine patients with severe infarction and one patient with cardiogenic shock. In all instances resuscitative measures were unrewarding.

Arrhythmias and Preexisting Heart Disease.—The presence of angina pectoris in patients with arteriosclerotic heart disease suggests severe coronary artery narrowing. The occurrence of one or more myocardial infarctions denotes that varying amounts of heart muscles have been replaced by scar tissue, and the prior existence of congestive heart failure signifies poor myocardial reserve. Thus, hearts so afflicted may be expected to perform poorly when deprived of effective myocardial tissue by an acute coronary occlusion. This was observed to be true in this series, as shown in Table 6. The mortality rate of patients with preexisting heart disease was higher than in patients with no such history.

A history of preexisting heart disease had no effect on the incidence or mortality rate of patients with arrhythmias of electrical failure, electrical instability, or potential electrical instability. Arrhythmias of pump failure were seen in the large majority of patients with prior heart failure (85 percent). When patients with preexisting heart disease developed arrhythmias of pump failure, the prognosis was grave, carrying a mortality rate of over 50 percent.

Discussion

The existing shortage of coronary care unit beds and disappointment in application of resuscitative measures have caused many physicians to ask: Which group of patients would benefit from this mode of highly organized therapy? In an effort to answer this question, many workers have attempted to establish the identity of patients most

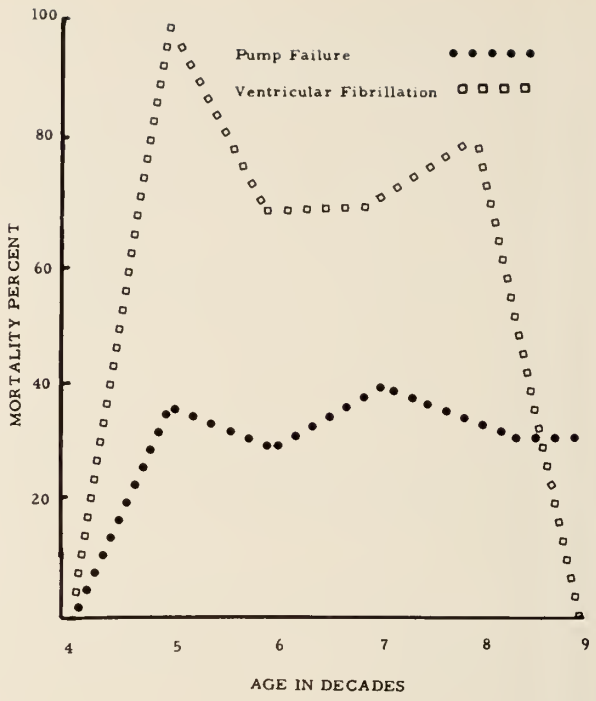


Fig. 2. Fatality rate in arrhythmias of pump failure and ventricular fibrillation in relation to age.

prone to develop cardiac arrest. This has resulted in a variety of patient profiles.

Julian, et al[3] have observed that ventricular fibrillation in hospital patients occurred at a relatively young age and predominantly affected males. Our study shows that ventricular fibrillation occurred in all age groups and was unrelated to the sex of the patient. Similarly, the chances of successful resuscitation from ventricular fibrillation were not affected by age or sex. Successful resuscitation with hospital discharge was achieved at all age decades. Mower, et al,[19] reporting on the mode of death in patients succumbing to an acute myocardial infarction, concluded that age did not influence the likelihood of a patient dying a rhythm death.

The age[4,20] and sex[6] of the patient has served as a partially limiting factor in the admission policy of certain coronary care units. Our experience suggests that a flexible admission and discharge policy, based on the general condition and hemodynamic status of the patient together with the demand for coronary care unit beds, is preferable to one employing an age or sex criterion.

It has been estimated that almost half the deaths from acute myocardial infarction result from rhythm disturbances.[19,21] Cardiac arrest, developing during the early postinfarction hours,

has been shown to be due almost exclusively to ventricular fibrillation,[22] primary ventricular asystole being a rare event.[3,4,23] Pantridge and Geddes[22] have estimated that the risk of dysrhythmia occurring during the first four postinfarction hours is almost 25 times greater than the risk between the 12th and 24th hours.

Though most authors agree that cardiac arrest is most likely to occur on the first hospital day, [3,6,24] relatively late cardiac arrest does occur in significant numbers. Restieux, et al[7] have pointed to its development well into the third week, with a high incidence between the fourth and 15th hospital days. This raises the important question of the duration of stay in the coronary care unit.

We have observed that the time of occurrence of ventricular fibrillation is related to the severity of infarction. All patients with clinically mild infarction developed ventrical fibrillation within the first 24 hours. All were successfully resuscitated and discharged alive. A delayed occurrence of ventricular fibrillation in this group of patients should warn the clinician of a possible reinfarction, as occurred in one patient. As these relatively "good risk" patients are the ones most likely to recover from prompt institution of resuscitation,[4,6] they should be considered choice candidates for coronary care unit therapy, since this provides the optimum environment for the early detection and prompt therapy of ventricular fibrillation. Every effort to reduce the time delay in admission to the unit should be made.

If a satisfactory hemodynamic and electrical state of the heart is maintained for a period of 48 hours in patients with clinically mild infarctions, electronic surveillance should be discontinued and patients transferred to an adjoining cardiac convalescent floor. Such a policy will make beds available to more deserving patients at no added risk.

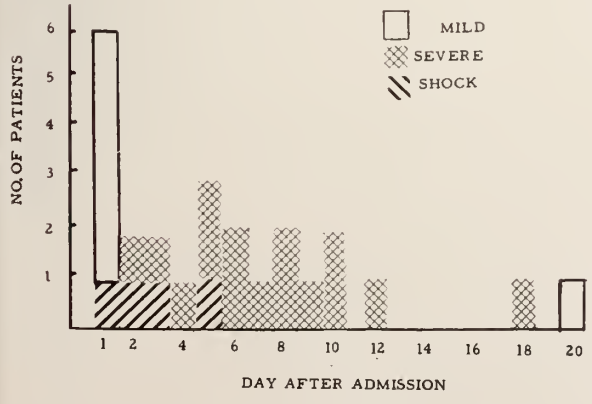


Fig. 3. Clinical severity of infarction and time of occurrence of ventricular fibrillation.

In patients with severe infarctions, the risk of ventricular fibrillation was greatest between the fifth and tenth days. Fifteen patients with severe infarctions developed ventricular fibrillation. In nine patients, there was evidence of overt cardiac failure, and the ventricular fibrillation could be considered truly secondary.[25] However, in the remaining six patients, ventricular fibrillation developed in the absence of any overt failure. Four of these patients were successfully resuscitated, two succumbed to a fatal recurrence within 24 hours, and the other two had an uneventful course until hospital discharge.

The disparity in time of occurrence of ventricular fibrillation in patients with no evidence of cardiac failure and those patients displaying hemodynamic alterations implies differing factors in the genesis of ventricular fibrillation. The early occurrence of ventricular fibrillation in patients with mild infarctions perhaps suggests a vicious interplay of ischemic ventricular irritability,[26] hormonal, and biochemical factors.[27,28] These factors have been shown to be present early in the course of myocardial infarction with subsequent normalization. They cannot therefore be held wholly responsible for a delayed episode of ventricular fibrillation. In patients with evidence of left ventricular failure, certain factors like hypoxemia, metabolic acidosis, and electrolyte imbalance, which are known to reduce ventricular threshold, are frequently present. The existence of these factors with concomitant use of inotropic, pressor,[2] or diuretic agents,[7] commonly employed in therapy of these patients, may well contribute to electrical failure in this group of patients.

From our experience, we feel that patients with severe infarction should be retained in the coronary care unit until significant cardiac failure or arrhythmias are controlled or reversed. Prompt attention should be paid to correction of hypoxia, humoral, and biochemical alterations. All medications should be administered judiciously.

In patients with cardiogenic shock, occurrence of ventricular fibrillation is perhaps related to the use of pressor amines.[8] Over-enthusiastic resuscitative measures may at best produce a period of decerebrate existence. The need, in these critical patients, for measures to assist the acutely failing left ventrical is far greater than electronic surveillance of rhythm.

In contrast to ventricular fibrillation, results of resuscitation in patients with unexpected ventricular asystole are discouraging, irrespective of clinical severity of infarction. We have had no success in resuscitating patients with asystole. Similar experiences were shared by Julian, et al[3] and Goble, et al.[6]

Ventricular asystole is the common mechanism of death in patients with pump failure, which suggests a lack of myocardial reserve. The prospects of reviving these hearts are necessarily slim. However, unexpected ventricular asystole does occur in patients with no overt failure and this was the case in four of the patients in this study. Two of these had a ventricular rupture discovered at necropsy. Autopsy could not be carried out on the other two patients, so it remains speculative as to whether the resuscitative failure was due to an irreversible anatomic lesion or a reversible physiologic process.

Arrhythmias of Pump Failure.—These arrhythmias were commonly (84 percent) seen in patients exhibiting some clinical evidence of left ventricular failure. Mower, et al[19] observed that older patients die more frequently from heart failure than expected and attributed this to the greater amount of fibrosis present in their hearts. This observation is reflected in this series by the increasing incidence of arrhythmias of pump failure with advancing age. The mortality rate associated with this group of arrhythmias was significant (30 percent) but was uninfluenced by the age of the patient. This would suggest that although the incidence of arrhythmias of pump failure increased with advancing years, the factor of age was not responsible for the accompanying mortality. This supports the contention held by Russek[29] that age itself does not kill but that it is associated with a greater number of complications.

The etiology, natural course, and mortality rate of arrhythmias of pump failure has always been a point of dispute, particularly with reference to atrial fibrillation. The incidence of atrial fibrillation has varied from 6 percent to 21 percent.[2,3,30,31] It has been considered benign, self-limiting, and transient by some workers,[3,5,6,30,31] and to be persistently morbid and associated with a high mortality rate by others.[32] The disparity in its natural course was found to be related to the clinical severity of infarction. It was transient, benign, and self-limiting in patients with mild infarctions, and persistent and associated with a high mortality rate in patients with evidence of circulatory embarrassment. Whether this difference is a reflection of a more severe degree of anatomic disruption in patients with severe infarction as opposed to patients with mild infarction remains a matter of speculation. Animal experiments have shown that neither loss of sinus node dominance nor atrial infarction by itself produces atrial arrhythmias. This led James[33] to conclude that the development of atrial arrhythmias was due to a combination of factors comprising decreased sinus node dominance, impaired impulse transmission, vagal reflexes, A-V node injury, extranodal injury, atrial distension, increased circulating catecholamines, hypercalcemia, or iatrogenic causes.

The increased left ventricular diastolic pressure observed in patients with left ventricular failure and the resulting rise of left atrial pressure with consequent stretch of the atrial wall may well account for the more persistent and morbid course of atrial fibrillation in these patients. Since these arrhythmias are known to have a deleterious effect on cardiac output, coronary perfusion, and ventricular performance, their continuation may further aggravate the existing failure and set up a vicious cycle. This demands prompt institution of therapeutic measures to improve left ventricular performance. The ultimate prognosis would depend on the reserve capacity of the myocardium.

Another factor that was found to have an unfavorable prognosis in patients with arrhythmias of pump failure was the prior cardiovascular status of the patient. The prior existence of angina pectoris, myocardial infarction, or congestive heart failure denotes a dimunition of the reserve capacity of the myocardium. Therefore it is not surprising to note that when patients with a prior history of one of these ailments developed arrhythmias of pump failure, the mortality rate in these patients was twice that of patients with no such previous ailment.

Pump failure now constitutes the major cause of death in hospital patients with an acute myocardial infarction. Newer methods of therapy are urgently required to assist the acutely failing left ventricle. In attemping to reduce the mortality rate in this group of patients, mechanical assist devices and hyperbaric oxygenation are currently on trial in this hospital.

Arrhythmias of Potential Electrical Instability.—Studies of the prognostic significance of acute heart block in patients with myocardial infarction reveal a high mortality. The block usually occurs within the first week and lasts from a few hours to several days. It seldoms leaves survivors with a permanent conduction defect.[1,3] Many modes of therapy have been resorted to, with varying degrees of success, in an attempt to reduce the high mortality rate. Atropine, isoproterenol, steroids, polarizing solutions, and chlorothiazide have all been employed with enthusiastic claims.

More recently the advent of intracardiac pacing has focused a great deal of attention on this subject. Although it may appear that the pacemaker was lifesaving in individual cases,[34] its role in severely ill patients is questionable. Friedberg, et al,[35] compiling results of 14 series where intracardiac pacemaker therapy was employed, found a mortality rate of 50 percent in

131 patients. The tendency to employ this therapy in some critically ill patients may have contributed to the poor results. The mortality rate is no different from series not employing electrical stimulation.[3,36]

Results of various modes of therapy employed in acute heart block are difficult to assess because of lack of a control series, the paucity of reports, the small number of cases in almost all reports, the transient nature of this conduction disturbance, the tendency for it to be associated with ventricular fibrillation and asystole, the liability of its occurring in severely damaged hearts, and inadequate data regarding coexistent complicating factors.

It is felt that, although the use of intracardiac pacing has theoretical appeal, its use is associated with formidable risks and precludes its routine employment in acute heart block. Reports of induction of arrhythmias, production of ventricular fibrillation by stimulating during the vulnerable period, sepsis, perforation, and troublesome mechanical failure are not lacking in the literature. The presence of these formidable risks creates the need to know which patients would profit most from this therapy.

Introduction of intracardiac pacing electrodes has been advocated by some workers[37] in sinus node dysfunction and incomplete heart block. The results of our study show that a satisfactory heart rate was achieved and progression to complete heart block did not occur in any of the patients with mild infarction. Hence even the elective passage of electrode catheters seems unwarranted in this class of patients.

Among the 20 patients with severe infarction and either sinus bradycardia or incomplete heart block, a satisfactory ventricular rate was either observed or obtained by pharmacologic means in all patients. Progression to complete heart block occurred in eight patients. In six of these, a satisfactory ventricular rate was achieved. Therefore, we feel that intracardiac pacing should be reserved only for those individuals in whom adequate control of heart failure, Stokes-Adams attacks, or heart rate cannot be obtained by drug therapy. In cardiographic shock, we observed complete heart block in one instance as an agonal rhythm, which was probably a manifestation of "power failure."[38] In this critical situation, no mode of therapy has yet yielded consistent good results. Sporadic reports of successful intracardiac pacing in patients with cardiogenic shock with acute heart block are seen in the literature and its prompt use in this situation appears justifiable.[39,40]

We did not employ intracardiac pacing during the period of review. Over this period, nine patients developed complete heart block and five of these died. An autopsy was obtained in three patients, and this demonstrated irreversible disease that precluded survival in each patient (myocardial rupture in two, severe cardiomegaly, rheumatic mitral valve incompetence, and an extensive posterior wall myocardial infarction in one). In the two patients on whom an autopsy was not obtained, one was in intractable cardiogenic shock 20 hours prior to agonal complete heart block. The other patient developed unexpected ventricular asystole 40 hours after he was restored to a normal sinus rhythm. Though a sudden development of ventricular asystole after a period of sinus rhythm is known, proof that it is a manifestation of disturbed conduction is lacking.

In all four patients who survived, none was left with a permanent block. The benign and transient nature of the heart block in surviving patients and the overwhelming clinical and pathologic derangement observed in fatal instances, suggests that mortality rate in complete heart block is unrelated to the heart block per se but that it is a manifestation of the severity of infarction and the state of the underlying myocardium. It is questionable whether electrical stimulation would have favorably altered the course of any of the fatal cases.

Arrhythmias of Electrical Instability.—These arrhythmias owe their significance to their potential for developing electrical failure. Ventricular ectopic beats were the most frequently observed arrhythmias and were little affected by any of the risk factors. They were found to be preexistent in all patients who developed ventricular fibrillation. The R on T phenomenon, with subsequent development of ventricular fibrillation, was recorded in one instance.

Fluck, et al[1] have observed the infrequency of ventricular tachycardia in patients with good general condition. We have seen this occur in only six patients with mild infarctions. In all of these, it was unsustained and did not progress to ventricular fibrillation. The low incidence of ventricular tachycardia in this series compared to the 28 percent incidence by Lown (1967) may in part be secondary to the greater number of mild infarctions seen in this series.

Ventricular fibrillation ensuing from ventricular tachycardia was observed in nine instances. All of these patients had severe infarctions and attempts to resuscitate were futile. Similar observations of the poor results obtained from resuscitative efforts in patients whose ventricular fibrillation was preceded by ventricular tachycardia have been observed by Julian.

In view of the fact that arrhythmias of electrical instability are harbingers of electrical failure, they should be treated aggressively. That this attitude may significantly reduce the incidence of

ventricular fibrillation has been shown by Lown, et al.[8]

The incidence and prognosis of arrhythmias are always difficult to assess. We have referred here only to a few factors related to their assessment. An important factor not covered in this discussion is the anatomic site of infarction, the topic having been dealt with by others.[1,27,30,33] We feel that factors such as hypertension, diabetes mellitus, and the size of the heart must also be given due weight in assessing the outcome of arrhythmias.

Summary

During a 2½ year period (1965 to 1968) the records of 250 patients with proven myocardial infarctions admitted to the Coronary Care Unit of St. Vincents Charity Hospital were reviewed. The incidence, natural course, and mortality of arrhythmias observed in these patients were studied with reference to the age, sex, multiplicity of arrhythmias, clinical severity of infarction, and the presence of preexisting heart disease in the patient. Arrhythmias were categorized into four types.

It was observed that arrhythmias of pump failure increased with advancing age. No relationship could be established between patient age and the other three categories of rhythm disorders. Ventricular fibrillation developed at all age groups. Chances of successful resuscitation in these patients were not related to patient age.

The sex of the patient did not influence arrhythmias. A greater number of women developed arrhythmias of pump failure, but this was related to the fact that women developed myocardial infarction at an older age.

Major arrhythmias were essentially multiple. Multiple arrhythmias had a worse prognosis than lone arrhythmias. Patients with atrial arrhythmias or ventricular tachycardia, who subsequently developed ventricular fibrillation, had a grave prognosis.

The incidence of all categories of arrhythmias increased with increasing clinical severity of infarction. Ventricular fibrillation was found to develop in the first 24-hour postinfarction period in patients with mild infarctions, and was relatively delayed in patients with severe infarction. Attempts at resuscitation from ventricular fibrillation were excellent in clinically mild cases and fair in the severe group. Ventricular asystole was considered a rare event in the absence of clinical evidence of overt pump failure.

Mortality rate in complete heart block was related to the state of the underlying myocardium and the clinical severity of the infarction, rather than to the conduction disturbance.

Patients with clinically mild infarctions developing sinus bradycardia or incomplete heart block did not progress to complete heart block.

The prior existence of angina pectoris, myocardial infarction, or heart failure in patients did not influence the incidence of arrhythmias. It did, however, adversely affect the natural course and mortality rate of arrhythmias of pump failure in those patients in whom it developed.

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Self-Evaluation Quiz

1. In caring for a patient with a spinal cord injury, you note on rounds that the patient has a reddened indurated area over the left greater trochanteric area. Your instructions to the nursing staff include the following as the *most* important:

   (A) Apply tincture of benzoin compound three times daily
   (B) Turn patient every 2 hours using four sides and omitting left lateral position
   (C) Scrub the affected area with antiseptic soap
   (D) Apply local antibiotic ointment
   (E) Put patient on an alternating pressure mattress in supine position

[*From the Department of Physical Medicine, The Ohio State University College of Medicine. The answer is given on p. 588 of this issue.—Ed.*]

Esophageal Retention Cyst

An Unusual Entity

Frank S. McCullough, M.D., Karl P. Klassen, M.D., and Floyd M. Beman, M.D.

ESOPHAGEAL CYSTS are unusual lesions which are rarely encountered.[1] This report describes a patient with an acquired esophageal cyst who illustrates the problem of differential diagnosis of pedunculated esophageal tumors. In addition, detailed histologic studies of the cystic lesion were performed and provide a possible explanation for the development of such lesions.

Case Report

This was the first Ohio State University Hospital admission for a 71-year-old white woman, who was admitted with a five-month history of abdominal bloating and several black, tarry stools. Gastrointestinal x-rays had been obtained elsewhere, and these revealed the presence of a mass lesion in the distal esophagus. The patient was referred to University Hospital for further evaluation. There was a history of a gradual 20 pound weight loss over the preceding two years. The patient specifically denied dysphagia, nausea, vomiting, abdominal pain, and any history of ingestion of caustic substances. An upper gastrointestinal series obtained in our clinic 12 years prior to admission was interpreted as normal. Physical examination revealed a pleasant, elderly housewife who did not appear ill. The pulse was 84 beats per minute, the respiratory rate 14 per minute, the blood pressure 120/70 mm.Hg, and the temperature was 98.6F. Examination of the heart, lungs, and abdomen was normal. The only abnormality noted on physical examination was a 1 cm. nodule in the left lobe of the thyroid.

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Laboratory studies revealed a hematocrit of 47 percent, hemoglobin 15.5 gm per 100 cc., and white blood cell count (WBC) of 7900 per cu. mm. with a normal differential count. Stool examination for occult blood was negative. The urinalysis, blood urea nitrogen, serum creatinine, serum electrolytes, serum calcium, and serum uric acid were all within normal limits. All tests of liver function, including a bromsulphalein (BSP) retention test, were within normal limits. Tests of thyroid function were within normal limits. A radioactive ^{131}I thyroid scan revealed a nonfunctioning nodule in the left lobe with increased uptake in the right lobe. Chest x-ray and barium enema were interpreted as normal. The upper gastrointestinal series revealed a normal stomach and duodenum. At fluoroscopy a 2 to 3 cm. mass on a stalk was noted in the distal esophagus and was seen to move freely between the esophageal vestibule and the cardia of the stomach (Figs. 1A and 1B).

Esophagoscopy revealed a 3 cm. smooth

polypoid mass on a stalk in the distal esophagus. The mass was observed to move freely from the esophagus to the cardia of the stomach but was felt to originate in the esophagus. No other abnormalities were noted. Although the mass appeared to be benign, the history of melena and the size of the lesion were felt to represent indications for its removal. A left thoracotomy was performed and an esophagotomy was made in the distal esophagus, exposing a 2 cm. pedunculated cystic mass which was excised without difficulty. The postoperative course was uneventful and the patient is currently in good health.

On pathologic examination, the cyst was smooth and measured 2 x 1.5 x 1.5 cm. (Fig. 2A). The cut surface of the cyst revealed a white gelatinous material. Histologic examination of the cyst demonstrated pink-staining mucinous material (Fig. 2B). The cyst was lined with several layers of flattened epithelial cells. Several smaller cysts were also noted and appeared to arise adjacent to minor salivary glands (Fig. 2B).

Discussion

Fewer than 50 esophageal cysts have been described in the medical literature.[2] Most are congenital in origin[3] and occur in the distal one half of the esophagus between the muscle layers of the esophageal wall.[4] They may resemble bronchogenic cysts, and indeed bronchogenic cysts have been described within the esophagus.[5] However, bronchogenic cysts may be distinguished from those of purely esophageal origin by the presence of cartilage within the cyst wall.[5] Cysts containing gastric-like glandular tissue have been described in a para-esophageal location.[6] This type of lesion is more likely to result in bleeding than those not containing gastric secretory epithelium.[7]

The origin of congenital esophageal cysts has been postulated to be either a diverticulum of the foregut occurring in fetal life or a remnant of the omphalomesenteric duct.[4] One previously described acquired retention cyst was noted in the glandular ducts of the esophagus.[2] The histologic appearance of that lesion was similar to that of our case, although the former was not pedunculated. It is possible that the cyst in our patient may have resulted from obstruction of the fine ducts in the minor salivary glands of the esophagus.

The symptoms of esophageal cysts are similar



FIG. 1A. Esophagram demonstrating cyst within esophagus.



FIG. 1B. Esophagram demonstrating same cyst in cardia of stomach.

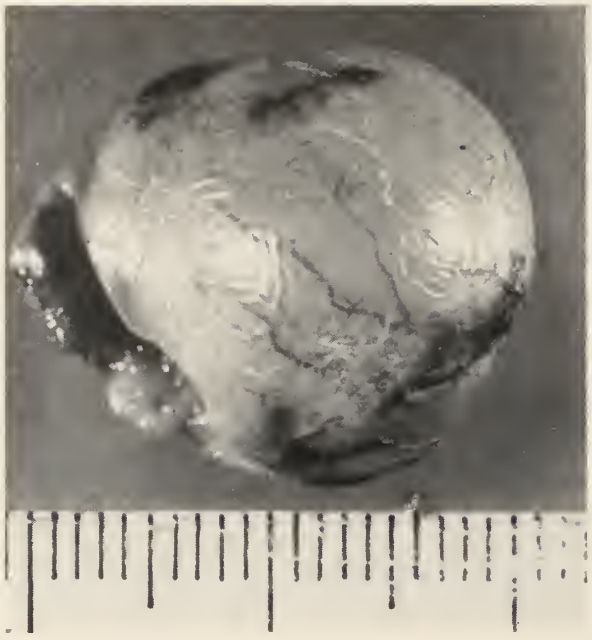


Fig. 2A. Gross appearance of cyst after excision.



Fig. 2B. Photomicrograph of cyst illustrating proximity of cyst wall (C) to minor salivary glands (G). (Original hematoxylin and eosin x approx. 100).

to those of other types of intraluminal lesions and do not provide any aid in assessing the nature of the tumor.[1] Even in retrospect, we found it difficult to explain our patient's complaints of bloating and weight loss on the basis of the esophageal cyst. She had noted some tarry stools prior to admission, but the stool guaiac reaction for occult blood was negative, the hemoglobin value was normal, and there was no evidence of recent or old bleeding from the cyst at surgery. The fact that the lesion was pedunculated suggested that it was benign, but a few cases of pedunculated esophageal carcinomas have been described.[8] The differential diagnosis of pedunculated intraluminal esophageal tumors includes adenomatous polyps, carcinoma, fibromas, and leiomyomas.[8] We have been unable to find a previous report of a pedunculated esophageal cyst.

Summary

A 71-year-old white woman with an acquired esophageal retention cyst is presented. Although rare, this lesion must be considered in the differential diagnosis of pedunculated esophageal tumors. The histologic appearance of the lesion suggests that it may have resulted from obstruction of the fine ducts leading from the minor esophageal salivary glands.

Acknowledgement: The authors wish to thank William J. Holaday, M.D. for preparing the photomicrographs.

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ALCOHOLISM will be the subject of a comprehensive symposium that will appear in *The Journal* for July and August, 1970—watch for this outstanding feature in the OSMJ.

Rectosigmoid Carcinoid Tumor

Report of a Fatal Case Discovered During the Puerperium

NORMAN E. MATTHEWS, M.D.

CARCINOID TUMORS have rarely been reported in association with pregnancy. In 1965 Berrios, et al stated they had discovered only two cases in a review of the literature back to 1916. They added four new cases.[3] The present report summarizes reports of five other cases from the literature and presents yet another, the second case of rectal carcinoid to be reported in association with pregnancy.

Case Report

This patient was a 39-year-old, gravida 3, para 2, abortus 1, who was admitted April 4, 1968, exactly six weeks postpartum, with complaints of weakness and generalized aching for three weeks. She had had a spontaneous, complete three-month abortion in 1961. In 1967, with no prenatal care, she had a term vaginal delivery. There were no apparent complications then except for a blood pressure of 170/85 mm. Hg. recorded at her six weeks postpartum examination. Treatment was not instituted and there was no further follow-up.

Her most recent pregnancy was complicated by intermittent blood pressure elevations to 140/90 mm. Hg. during the second trimester and by persistent levels of 150/90 mm. Hg. or higher near term. There was no proteinuria, and weight gain was not excessive. Labor was induced by an intravenous oxytocin infusion. Labor progressed without apparent complications to vaginal delivery of a living 3450 gram male infant. The infant's neonatal course was uncomplicated. The placenta delivered spontaneously and appeared intact. Her hematocrit value on the day before induction was 42 percent, and the estimated blood loss with delivery was 200 ml. Blood pressures during the first four postpartum days ranged from 115/75 mm. Hg. to 140/90 mm. Hg. with no definite downward trend. She was discharged from the hospital on the fifth postpartum day.

She was next seen in the hospital emergency room five weeks postpartum with complaints of left flank pain and increased urinary frequency of several days duration. She was afebrile and denied history of chills or fever. Urinalysis on a catheterized specimen revealed 2 to 8 white blood cells per high-power light field. She was treated with sulfisoxazole and phenazopyridine hydrochloride. Urine culture later disclosed no growth.

She returned next on April 4, 1968, exactly six weeks postpartum, with complaints of weakness and generalized aching for three weeks. She also related that vaginal bleeding since delivery had required at least three perineal pads daily. She developed, "pain around the waist and down the legs" the day prior to admission. She had taken oral iron medication daily since hospital discharge. No other symptoms were elicited except for chronic constipation.

Her blood pressure was 130/70 mm. Hg., pulse rate 132 beats per minute, temperature 102.4F, and respiration rate 20 per minute. She was very pale and appeared weak. Abdominal examination revealed an irregular, nontender, 10 X 10 centimeters mass in the left lower quadrant. The firm edge of her liver was palpable 3 to 4 centimeters below the right costal margin. On vaginal examination moderate bleeding from a patulous cervical os was noted, and tissue was palpable within the cervical canal. The uterus was enlarged to a size compatible with a three month intra-uterine gestation. The adnexal areas were normal, and the uterus was distinctly separate from the mass palpated abdominally.

Laboratory studies on admission disclosed the following values: hematocrit 22 percent; white blood cell count normal; urinalysis negative; stool guaiac 4 plus; blood urea nitrogen (BUN), fasting blood sugar (FBS) and serum electrolytes normal. A flat film of the abdomen demonstrated a midabdominal mass, and a chest x-ray was normal.

Over the next four days she was given therapeutic doses of penicillin and tetracycline. She was also given three units of packed red blood cells, but her temperature remained elevated (101F), and she remained anemic. During this period constant rectal bleeding was observed. On the fourth hospital day, uterine curettage and sigmoidoscopy were performed. A 2 gram fragment of tissue was obtained from the uterus, and an endophytic

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mucosal lesion was noted in the sigmoid colon at 23 cm. Multiple biopsies were from the latter. The pathologist's interpretation was "Carcinoma in sigmoid and necrotic tissue (placental polyp)" (Fig. 1). She became afebrile after the curettage, as antibiotic therapy was continued.

A barium enema revealed a constricting lesion 5 cm. in length in the colon (Fig. 2). In addition, there was an area of increased density and partial collapse of the body of the first lumbar vertebra. A liver scan showed hepatomegaly with multiple, large filling defects.

The patient was transferred to the general surgery service, where aspiration of sternal marrow demonstrated small clumps of tumor cells. In days that followed, a tender left breast nodule developed.

Her anemia persisted with hemoglobin determinations between 2 and 3 gm. per 100 ml. Alkaline phosphatase was 170 to 200 units per 100 ml. Serum glutamic oxaloacetic transaminase (SGOT), serum glutamic pyruvic transaminase (SGPT), and hydroxybutyric dehydrogenase were normal. Lactic dehydrogenase (LDH) was greater than 1800 milliunits per ml.

Despite multiple transfusions, she remained anemic. Her condition deteriorated rapidly, and it was decided not to intervene surgically since bowel obstruction was not a problem. She became progressively weaker and died on the 26th hospital (68th postpartum) day.

At autopsy a tumor of the sigmoid colon was found, measuring 20 X 15 X 7 centimeters. It varied from gray to black in color and contained areas of ulceration. There was local node involvement and massive liver involvement with tumor. An estimated 50 percent of the liver consisted of tumor. Metastatic tumor also was found in bone marrow, ovaries, adrenal glands, pancreas, lungs, heart, and left breast.

Microscopically the tumor consisted of relatively uniform, compact cells with pale staining, round, and even nuclei with occasional prominent nucleoli. Cytoplasmic borders were rather indistinct. Pseudorosettes, strands, and sheets of cell were seen (Fig. 3). Silver stain for argentaffin granules was negative. The histologic picture was characteristic of rectal carcinoid tumor. Other autopsy diagnoses were: passive congestion of the liver, fatty myocardial degeneration, pulmonary edema, and extramedullary hematopoiesis in the liver and spleen. The uterus was unremarkable at autopsy.

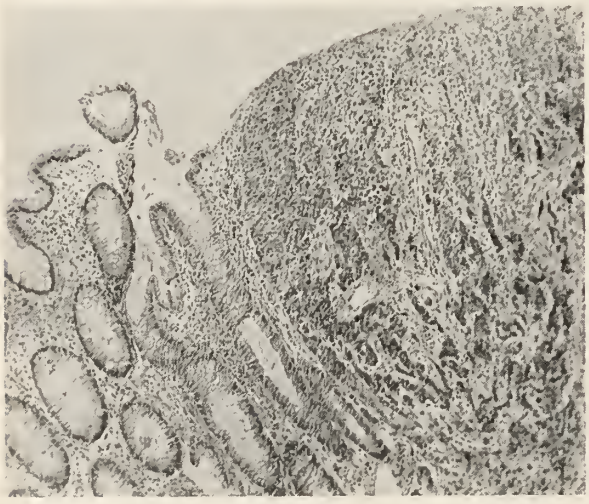


Fig. 1. Section of biopsy from rectosigmoid colon.



Fig. 2. Barium enema, demonstrating constricting lesion in rectosigmoid colon.

Discussion

Carcinoid tumors are generally felt to arise from argentaffin cells in the crypts of Lieberkühn. These cells are found along the gastrointestinal tract from the stomach to the rectum. They are located as single cells between the glandular cells and are identifiable with silver stains for argentaffin granules. The cells are known to produce serotonin and possibly histamine and other hormones.[6, 9]

Carcinoid tumors may occur anywhere in the small bowel or rectum. The occurrence rate is highest in the appendix, where one per 500 routine appendectomies is diagnosed.[1] There seems to be agreement that, although most carcinoids have not metastasized when removed, all are potentially malignant. Once spread has occurred from most sites of origin, the endocrine secretion can bypass the hepatic portal circulation, thus permitting the development of the so-called "carcinoid syndrome"—flushing, bronchoconstriction, diarrhea, and pulmonic vascular lesions due to subintimal collagen deposits.[9] Such cases are associated with elevated 5-hydroxyindoleacetic acid excretion in the urine. The morphology of the lesions resembles that described in this case, except that most carcinoids show an affinity for silver stains.

Rectal carcinoid tumors are peculiar in two respects. First, they do not take the silver stain. Second, of 440 reported cases in 1965, none had been associated with the carcinoid syndrome.[7] They occur slightly more frequently in males than in females, with age ranges in both sexes from the second to the eighth decades of life. In men the peak incidence is in the sixth decade. In women it is in the fifth.[2] The overall incidence of rectal carcinoid tumors is about 0.04 percent, about 5 percent of all carcinoid tumors, and about 0.8 percent of all gastrointestinal tumors.[4, 7, 11]

Most rectal lesions are yellow, not ulcerated, small (less than 1 cm.), and within 10 cm. of the

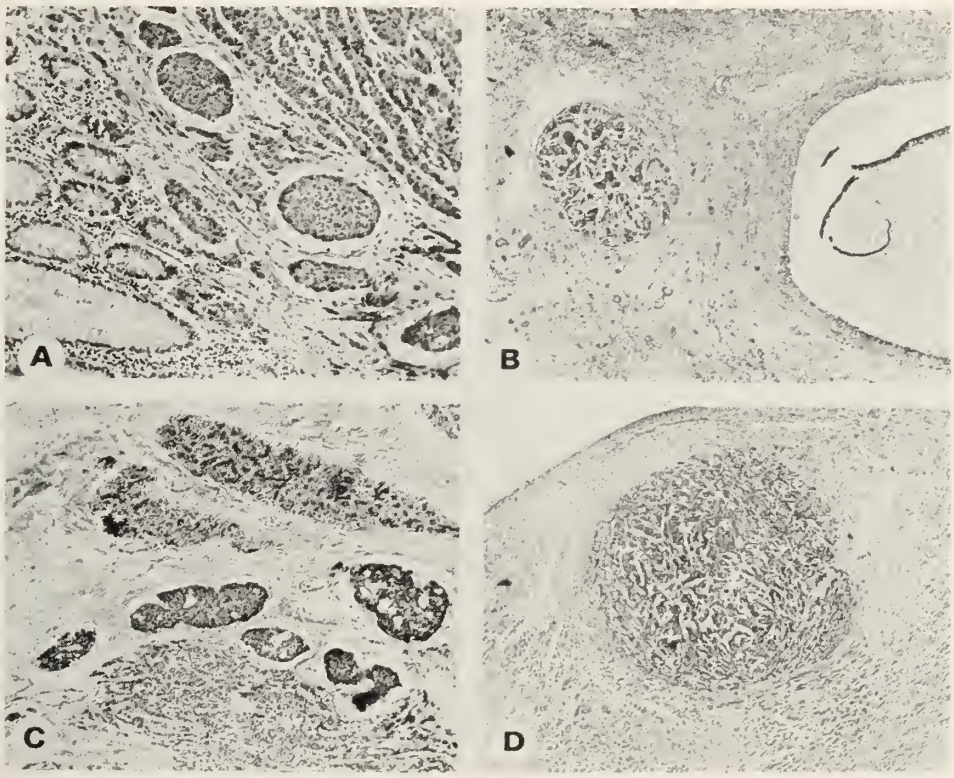


FIG. 3. Sections from autopsy (H&E). A. Rectosigmoid colon, demonstrating monotonous cellular pattern with cells in sheets and cords (x80). B. Ovary (x20). C. Left breast (x40). D. Heart (x20).

anus. Symptoms attributable to such tumors are rarely present, and they are most often discovered on routine examination.[11] Tumors under 1 cm. in size are rarely (1.7 percent) clinically malignant when discovered. Between 1 and 2 cm. size, the rate of clinical malignancy is 10 percent, and above 2 cm., it is 82 percent.[2] With the small tumors, local excision, therefore, is usually sufficient. Larger tumors demand more aggressive therapy.

Heretofore only one case of rectal carcinoid associated with pregnancy has been reported.[10] This was in a 21-year old Negro woman and was discovered on routine examination. It was found within 5 cm. of the anus, excised locally, and measured 3 X 2 X 1.5 mm. No symptoms were present.

Ten other cases of gastrointestinal carcinoid tumors associated with pregnancy have been reported. These are summarized in Table I. Three, and possibly four, were associated with the carcinoid syndrome.[8, 12] Three of these cases were associated with fetal loss. Two patients had midtrimester abortions and a third patient had four premature deliveries (one stillborn and three neonatal deaths at 2 to 36 hours of age). Unfortunately, case details are incomplete in all but one of these cases.

There have been six case reports of appendiceal carcinoid tumors during pregnancy.[3, 5, 13] Two were discovered at laparotomy for appendicitis and in the four other cases laparotomy was performed for obstetrical reasons. Five patients were treated by appendectomy alone, and one patient with a large lesion (6 X 3.5 cm.) underwent hemicolectomy. In none of these was distant spread noted.

Although her carcinoid tumor first became manifest on the 42nd postpartum day, our patient undoubtly had her tumor during pregnancy. One can assume, of course, no causal relationship between this tumor and her previous infertility.

At no time had she complained of symptoms suggesting carcinoid syndrome; therefore, no 5-hydroxyindoleacetic acid determinations were done. The tumor was highly malignant, evidently rapidly growing, and much larger than most rectal carcinoids.

Summary

The second case of rectal carcinoid tumor in association with pregnancy is reported, and the

Table 1. Ten Reported Cases of Gastrointestinal Carcinoid Tumors Associated with Pregnancy

Author	Age	Duration Gestation	Primary Site	Carcinoid Syndrome	Notes
Deturmey et al., 1957 (5)*	24	6 weeks	Appendix	No	Appendicitis with rupture—appendectomy. Criminal abortion 6 weeks later. Size of tumor not given. No spread.
Monteagude, 1961 (10)*	21	1 month	Rectum	No	Discovered on routine examination. 3 X 2 X 1.5 cm.—local excision.
Reddy et al., 1963 (12)*	35	8 months	Ileum	Yes	15-year history, 4 pregnancies, 3 premature neonatal deaths, 1 premature stillborn. Metastases to liver.
	22	2nd trimester	?	?	Aborted in 2nd trimester. Site and spread not stated, nor whether she had syndrome, only that she had "carcinoid tumor."
Leeper et al., 1966 (8, 14)*	22	18 weeks	?	Yes	Spontaneous abortion of normal 20.5 cm. male fetus. 24-hour 5HIAA 247 mg. Had adenocarcinoma in liver, type not specified.
	?	Term ?	?	Yes	No details of case except "carcinoid syndrome" present, live infant delivered.(14)*
Berrios et al., 1965 (3)*	23	2 months	Appendix	No	Appendicitis. 0.3 cm. nodule located at proximal end of appendix. Appendectomy.
	21	Term	Appendix	No	Incidental finding at cesarean section for cephalopelvic disproportion. Appendectomy. 1 X 2 cm. nodule.
	26	10 weeks	Appendix	No	Incidental finding at laparotomy for bleeding corpus luteum cyst, 1.5 cm.
	30	38 weeks	Appendix	No	Incidental finding at elective cesarean section and tubal ligation. Appendectomy. 9 mm.
Scott et al., 1968 (13)*	36	1 week postpartum	Appendix	No	Incidental finding at total abdominal hysterectomy for postpartum hemorrhage. Right hemicolectomy. 6 X 3.5 cm. No spread.
Matthews, 1969	39	6 weeks postpartum	Rectosigmoid	No	Widespread metastases, rapid progression and death.

*Reference number

literature on gastrointestinal carcinoid tumors in pregnancy is reviewed. This carcinoid tumor was discovered during the puerperium.

The association of carcinoid tumor with pregnancy is rare and probably random. When the carcinoid syndrome is present, it would appear to carry a poor prognosis for pregnancy. This syndrome has not been present in cases of carcinoid tumors of the rectum.

Generic and Trade Names of Drugs

Chloramphenicol — Chloromycetin (Park, Davis Co.)

Levarterenol bitartrate — Levophed (Winthrop Laboratories)

Nitrofurantoin — Furadantin (Eaton Laboratories)

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Von Recklinghausen's Disease Associated with Pheochromocytoma and Carcinoid Tumor

Hi Young Lee, M.D., and Pauline E. Garber, M.D.

RECENTLY we encountered an unusual case of von Recklinghausen's disease (RD) with neurofibromas of the stomach, duodenum, bladder, and psoas muscle and associated with pheochromocytoma. Additionally, this patient had carcinoid tumor of the duodenum and bilateral gynecomastia. We have not found in the literature any previous occurrence of these types of tumor in a single patient with such extensive visceral organ involvement of neurofibromatosis. For this reason the following case is reported.

The Authors

• Dr. Lee, Dayton, is Resident, Surgical Service, Veterans Administration Hospital and The Ohio State University College of Medicine.

• Dr. Garber, Dayton, was formerly Pathologist, Laboratory Service, Veterans Administration Hospital at Dayton.

Case Report

This 72-year-old white male had a diagnosis of RD and chronic, severe anxiety reaction since 1930. He had considerable difficulty with his eyes, involving enucleation of the left eye because of glaucoma in 1951. He also had essential hypertension. The patient manifested nervousness, generalized tremor, and occasional hallucinations.

In 1960 he developed progressive frequency and urgency of urination, and occasional dysuria and nocturia. Carcinoma of the prostrate was suspected, and a suprapubic prostatectomy was performed. However, tissue examination revealed chronic prostatitis.

The patient had had irregular bowel habits for approximately ten years. In 1965, the patient complained of pain in the left abdomen. A flat plate of the abdomen revealed a cystic tumor of the left upper abdominal cavity, which was calcified and measured 3 inches in diameter. However, in 1945 this had been documented in his chart as a pseudocyst of the pancreas (Fig. 1). Sigmoidoscopy and barium enema performed in 1960 were negative. For many years he took Bromo Seltzer® for abdominal discomfort. No abdominal surgery was done.

Review of the family history revealed that his mother died of an unknown disease, his father died suddenly at the age of 82 years, cause also unknown. Three sisters are living; one had an operation for goiter. One other family member had a mental disease.

The patient carried the diagnosis of paralysis agitans, neurofibromatosis, urethral stricture, status post suprapubic prostatectomy, status post enucleation of the left eye, status post cataract extraction from the right eye, anxiety reaction, and pulmonary emphysema until he died of bronchopneumonia on July 8, 1968.

Autopsy Findings

There were neurofibromas measuring 1 to 2 cm. covering the entire skin surface of the body

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Submitted January 21,1970.

with the exception of the soles and palms. There was bilateral gynecomastia measuring up to 3 cm. Hyperpigmented areas were noticed particularly on both sides of the anterior aspect of the leg.

The head of the pancreas was solid and nodular; however, extensive fibrosis occupied its body and tail. A calcified pseudocyst, weighing 185 grams was found in the location of the tail. (Fig. 2). In the duodenum, there was a carcinoid tumor, measuring 2 X 1 X 1 cm., located 1.7 cm. from the proximal level of the ampulla (Fig. 3). Two neurofibromas of similar size were located in the duodenum and in the last part of the small bowel. The gastric serosa contained multiple, minute neurofibromas about 2 X 0.8 X 1 cm. in size (Fig. 4).



Fig. 1. Intravenous pyelograph showing cyst of pancreas in 1945.



Fig. 2. Calcified pseudocyst of pancreas.

A striking feature was the hydronephrosis and hydro-ureter of the entire right side with inflammatory scars. A neurofibroma, measuring 2 X 1 X 1 cm., at the ureterovesical junction protruded into the lumen of the ureter, completely blocking it. The hydro-ureter extended beyond to this point. The bladder wall in this area was thickened and firm.

The aorta was widened and showed a very severe degree of arteriosclerosis. There was dilatation and thickening of the splenic artery, and common iliac artery aneurysms were present bilaterally. A neurofibroma measuring 3 X 4 X 3 cm. was loosely attached to the surface of the right psoas muscle. On the left side of one adrenal gland, we found pheochromocytoma. The left adrenal gland was not identified grossly. A 3 cm. mass of brownish-gray tissue attached to the surface of the pancreatic pseudocyst was microscopically identified as another pheochromocytoma.

In the brain, we found a thickening of the leptomeninges and degeneration of the left optic tract, but no glioma or other tumor.

Comments

Generalized neurofibromatosis was described by von Recklinghausen in 1882.[1] In 1949, Lichtenstein[2] interpreted the basic lesions in von Recklinghausen's disease as multiple foci of hyperplasia and neoplasia of supportive or protective derivatives of the ectoderm within the substance of the nervous system and established the common neuroectodermal embryogenesis theory. Manifestations such as cafe au lait spots, cutaneous neurofibromas, tumors of the central and peripheral nervous systems, skeletal changes of scoliosis, orbital wall defects, pseudoarthrosis, gigantism, and involvement of the renal artery, the bladder, and other visceral organs are well known.[3] We believe that our case shows neurofibromatosis to be a mesodermal as well as a neuroectodermal disorder.

Neurofibromatosis is not a very rare disease. It is present in many patients with mental retardation or epilepsy or accompanied by bizarre cerebrospinal or other symptoms but it may not be suspected. The patient is frequently of low intelligence. Incidence is equal among the Caucasian and Negro races, occurring about once in every 2,000 to 4,750 births. Hereditary factors have been noted in 20 percent of the reported cases.[4]

Confusion exists concerning the precise nature of the pathology, particularly since different types

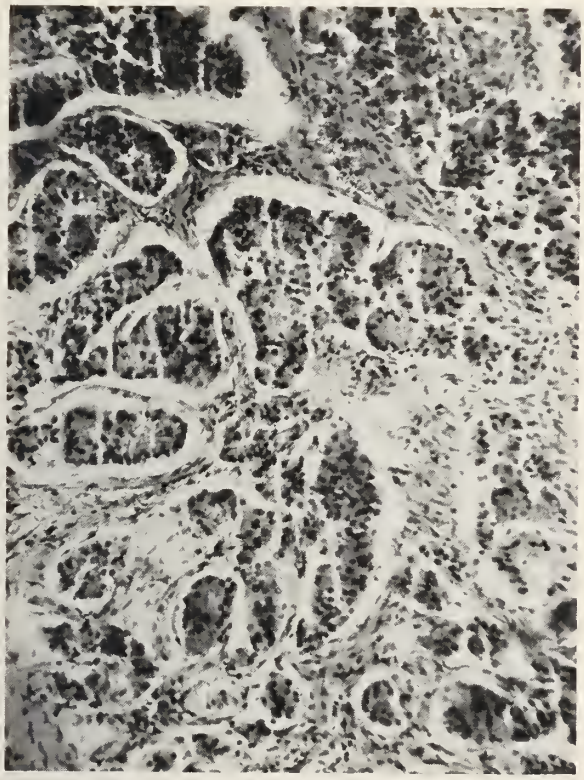


FIG. 3. Carcinoid of duodenum.



FIG. 4. Multiple neurofibromatosis of stomach.

of lesions may be present in one tumor. Moertel[5] stated that, in the general population, the rate of occurrence of multiple primary cancers is 10.6 percent at autopsy and 4.6 at operation. Neurofibroma is believed to originate in the fibrous connective tissue of the nerve sheath and not in the nerve itself. Visceral manifestations of von Recklinghausen's neurofibromatosis occur infrequently, but when they do, the gastrointestinal tract, and here especially the stomach, is the most common location, though such tumors have been reported as occurring in the pharynx, tongue, gallbladder, small bowel, appendix, sigmoid, and in the post-rectal area. Urinary tract involvement is comparatively rare, involving most often the bladder.[6] Weston, et al[7] reviewed the literature and found 23 reported cases of neurofibromatosis of the rectum. Perea, et al[8] reviewed 29 reported cases of stomach involvement of neurofibromatosis and found abdominal pain, anemia, and gastrointestinal bleeding to be the most frequent presenting symptoms. Occurrence of neurofibromatosis in the bladder was reported in 27 cases in the world literature.[9] When neurofibromatosis involves the bladder, the earliest symptoms are related to ureteral obstruction and to the infection which frequently accompanies the obstruction, as illustrated in our case.

Pearson and Fitzgerald[10] reported eight of 31 patients with carcinoid tumors of the small bowel and primary malignant lesions outside the small intestine. Alexander and Altemeer[11] stated that in subjects over 50 years of age with neoplasms of the small intestine and particularly with carcinoids, the presence of future development of other benign or malignant tumors elsewhere in the body must be suspected.

The assumption that multiple primary tumors arise independently has never gained much support. The finding of pheochromocytoma with neurofibromatosis in postmortem material is 20 percent and in a group diagnosed before death is 10 percent.[12]

Barnard,[13] reported astrocytic glioma of the cerebrum and cerebellum in a case of RD with pheochromocytoma and concluded that the neoplasm can operate over a wide field, producing multiple, independent, primary tumors derived from neuroectoderm. Some association of medullary carcinoma of the thyroid with neurofibromatosis has also been reported in the literature.[12] The possibility that the cell types involved in these tumors had the same embryologic origin may account for the coincidence.

Foregut carcinoids have been shown to secrete ACTH or ACTH-like hormones, melanocytic stimulating hormones, possibly antidiuretic hormones, catecholamine-epinephrine and norephinephrine, bradykinin, other kinins and histamines, as well as

serotonin.[14] Furthermore, a common pathogenesis of multiple endocrine tumors may be associated with RD.

Summary

The association of multiple primary tumors in a single patient has etiologic and diagnostic implications only if it can be shown that the occurrence is not fortuitous.

Occurrence of neurofibromatosis in the stomach was reported in 29 cases in the world literature. The occurrence in the bladder was reported in 27 cases in the literature.

An unusual case of the von Recklinghausen's neurofibromatosis with neurofibroma of the stomach, duodenum, bladder, and psoas muscle and associated pheochromocytoma, carcinoid tumor of the duodenum, and bilateral gynecomastia has been reported.

The cell types involved in all these tumors had perhaps the same embryologic origin. This probably accounts for the coincidence.

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Self-Evaluation Quiz

2. A 43-year-old woman visits her physician because of the recent onset of intermittent serosanguineous discharge from the nipple of the right breast. Examination confirms the drainage of bloody fluid when the breast is stroked from the periphery toward the nipple at the nine o'clock position. No mass is palpable. The proper management for this patient is:
   (A) Periodic examination of the breasts searching for a mass
   (B) Simple mastectomy and sectioning of the breast looking for the carcinoma
   (C) Antibiotic therapy to combat the mastitis
   (D) Mammography, and if this examination is negative, excision of a wedge of breast tissue at the nine o'clock position to remove the duct containing an intraductal papilloma

[*From the Department of Surgery, The Ohio State University College of Medicine. The answer and reference are given on p. 588 of this issue.—Ed*]

Treatment of Hypertension

Harriet P. Dustan, M.D.*

HYPERTENSION shortens life. Even the so-called benign hypertension causes premature death or disability and can scarcely be looked upon as benign. Considering that hypertension is potentially lethal, the question arises as to whether sustained reduction of arterial pressure prolongs life. There are two answers to this question: an unqualified "yes" and a "maybe," depending on whether reference is made to the complications of arteriolar disease or those of atherosclerosis. The most frequent results of hypertensive vascular disease—the term used for the arteriolar disease—are cardiac failure and malignant hypertension. In both instances blood pressure reduction is life-saving, providing, of course, that in the malignant hypertensive renal function is still adequate to sustain life. Clinical experience also indicates that good blood pressure control in hypertensive patients without these complications will prevent their occurrence. In contrast, the effects of antihypertensive treatment on the complications of atherosclerosis are not so clear as on those of hypertensive vascular disease, and here the "maybe" answer has to be given. The equivocation in this answer comes because antihypertensive drug treatment has not been used over a long enough period of time to assess its effects on the complications of atherosclerosis that so frequently accompany hypertension. However, there is some evidence which suggests that strokes, at least, occur less frequently in treated patients.

From the foregoing, the goals of antihypertensive treatment can be stated as: (1) to reduce arterial pressure to normal or as near normal as possible, (2) to prevent the progression of arteriolar disease and control its complications if they are present, and (3) to prevent the development of premature atherosclerosis—or at least to prevent or postpone the development of its complications.

There is a variety of ways to treat hypertension effectively. Some are specific in that they eliminate or block a pressor mechanism and thus reduce arterial pressure to normal. Others can be called nonspecific because, although hypertension is greatly lessened, arterial pressure does not become normal. The treatments, which in my opinion are specific, are both surgical and medical. In a young patient with renal arterial stenosis, a successful operation—either a revascularization procedure or nephrectomy—usually completely eliminates the hypertension. In a substantial number of patients with pheochromocytoma, primary aldosteronism, and coarctation of the aorta similar results are achieved by operative treatment. Certain drug treatments also achieve complete normalization of arterial pressure. Thus, in patients with primary aldosteronism, administration of spironolactone eliminates hypertension as surely as does operative removal of the tumor; and in patients with increased activity of the beta-adrenergic component of the sympathetic nervous system, use of a beta-blocking drug such as propranolol not only abolishes the symptoms but also reduces arterial pressure to completely normal levels.

The experience with these "specific" treatments is striking because such results are usually not achieved when the pressor mechanism is not approached directly. For example, contrast the blood pressure reduction achievable by successful operative treatment in a patient with renovascular

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Provided by the American Heart Association, Inc. and made available to *The Journal* by the Ohio State Heart Association.

hypertension with the result produced in the same patient by a drug, like alpha methyl dopa, that suppresses sympathetic vasomotor activity. In the former instance, the operation eliminates the pressor factor(s), while in the latter drug treatment lessons the hypertension but does not eliminate it. The operative treatment is specific, while the drug treatment is nonspecific or empiric.

The fact that most drug treatment of hypertension is empiric is not to say that it is unsuccessful, because substantial reductions in arterial pressure can usually be achieved. There are a number of drugs available which are effective and, for the most part, reasonably easy to take. Two types are most commonly used—oral diuretics and drugs that suppress the activity of the sympathetic nervous system through effects on production, storage, or release of the neurotransmitter, norepinephrine. The former group includes chlorothiazide and its derivatives, as well as ethacrynic acid and triamterene; the latter comprise ganglion-blocking drugs, reserpine, guanethidine, alpha methyl dopa, and pargyline. Not included in these two groups is hydralazine, which seems to act directly on the arterial wall. The anti-aldosterone drug, spironolactone, has value as nonspecific treatment when used to combat the potassium losing effects of chlorothiazide diuretics.

When used in adequate doses, these drugs usually achieve good blood pressure control. When more than one drug is used, combination tablets are not the best way to administer the medication because there is need to individualize the dose of each drug. The most frequent combination of drugs is an oral diuretic with another type, because usually there is a synergistic effect on blood pressure reduction—the combination achieving a better result than would be expected from purely additive effects of the two drugs. Not more than one type of chlorothiazide diuretic should be given in a treatment regimen, and, also, there is no evidence that giving more than one type of adrenergic-blocking drug—such as combining guanethidine with methyl dopa—adds any benefit.

When it is necessary to reduce blood pressure rapidly, as in patients with cardiac failure, intracerebral bleeding, or hypertensive encephalopathy, good results can usually be achieved by the potent peripherally acting sodium nitroprusside or diazoxide given intravenously. More readily available, but less potent, are preparations of reserpine, hydralazine, methyl dopa, and ganglion-blocking drugs suitable for parenteral administration.

One crucial question in the long-term treatment of hypertension concerns how to judge the effect of treatment. Actually, use of office pressure measurements is usually unsatisfactory, but for certain patients there is no other way. However, many patients can learn to make their own measurements, and this provides a daily record of responses and allows for judicious adjustment of doses whenever indicated. One mistake that many clinicians make is failure to obtain a good pretreatment arterial pressure record, and this difficulty can be obviated by use of home readings. The technic is easy to learn, and the measurement is no more difficult to carry out than estimation of urinary sugar—information considered a must in the treatment of diabetes.

With home readings, the physician has the advantage of judging the effects of treatment in two situations rather than one because he additionally obtains office readings when the patient visits him. The more detailed record of treatment response that is available the better the treatment can be managed.

In some patients with hypertension of unknown cause, use of nonspecific drug treatments detailed above reduces arterial pressure to normal just as specific treatments do in patients with known types of hypertension. Such responses show that each type of treatment can be specific when properly chosen; the current problem is that, for the most part, there is no sure way to make the proper choice. Currently, the challenge of investigation is to learn enough about the mechanisms of hypertension and how they are interrelated so that specific, rather than empiric, treatments can be given to each hypertensive patient.

Answers to Self-Evaluation Quiz

Page 575 Question 1. (B) There is an incipient pressure sore and the only way to prevent these is to turn the patient every two hours. If capillary pressure of 30 mm of mercury is exceeded for more than 1½ or 2 hours, tissue necrosis can occur.

Page 586 Question 2. (D)

Reference: Leis, H. P., Jr.; Dursi, J.; and Mersheimer, W. L.: Nipple Discharge: Significance and Treatment. *N. Y. J. Med.*, **67**:3105-3110, 1967.

Maternal Deaths Due to Sepsis with Septic Shock*

By the OSMA Committee on Maternal Health

With Comment of Consulting Obstetrician and Gynecologist

TO GAIN some insight into the importance of infection in maternal deaths, one may consult the Maternal Mortality Report for Ohio published by The OSMA Committee on Maternal Health covering ten years, 1955 thru 1964.[1] Infection has maintained its prominent position as the number two cause of death with 157 maternal deaths attributed to infection during these years; the total number of maternal deaths being surveyed was 779. In a representative year, 1964,[1] there were 59 maternal deaths, 21 attributed to infection. In 1965 in the State of Ohio, there were 42 maternal deaths with infection again listed as second only to hemorrhage as cause of death; seven women died of infections.[2]

Previously, the Committee has presented facts and features of maternal deaths due to *sepsis,* with septic shock, after criminal abortion.[3] Principally, *methods* employed to induce the illegal acts were documented in the article.

In this article, the Committee presents three cases in which the patient died of sepsis and "septic shock" following alleged criminal abortion. All were proved by the Coroner; the *causative organism* was isolated in each case.

Case No. 617

A 21-year-old, Negro, gravida VI, para III, abortus II, died undelivered, in her eighth week of gestation. Her past history included three term pregnancies delivered without complication, also, there were two nonseptic (first trimester) abortions without dilatation and curettage. With a last menstrual period February 15, the patient *denied* any intervention or instrumentation in the pregnancy, declaring a normal course until the day of admission. She came to the hospital through the emergency room, March 17, with chills, fever (101F), lower abdominal cramps, vaginal bleeding, vertigo and syncope. The blood pressure was 110/88 mm. Hg., pulse rate 120 beats per minute, and respiratory rate 20 per minute. Her uterine fundus was the size of an eight weeks pregnancy; the cervix was dilated two centimeters, tissue was in the os with a foul odor. Laboratory tests reported the leukocytes 38,000; hematocrit 36 percent; Lee-White clotting time 90 minutes; bleeding time three hours, and the fibrinogen was less than 100 mg. percent. Cultures of the cervix and (venous) blood grew *Clostridium perfringens* and *Escherichia coli-aerogenes.* Treatment included massive doses of penicillin, chloramphenacol, whole blood, four grams of fibrinogen, gas gangrene antitoxin, digitalization and vasopressors. In spite of therapy the patient developed irreversible *shock,* intravascular hemolysis, pulmonary edema, and terminal cardiac arrest. The patient died on March 18th, 19 hours after admission.

Cause of Death (coroner's autopsy): Acute septicemia *(Clostridium perfringens and coli-aerogenes);* infected abortion, probably self-induced; perforation of the uterus; hypofibrinogenemia; intravascular hemolysis; pulmonary edema; and irreversible shock.

Comment

The Committee studied meager facts in the case, noting the patient denied any act or attempt to interrupt the pregnancy. Obviously, the heroic attempts to provide prompt, adequate management were futile due to overwhelming sepsis.

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

The Committee voted this a preventable maternal death, patient responsibility.

Case No. 766

A 23-year-old Negro woman was dead on arrival at the hospital on August 9. Facts in her past history were not known. The husband did give information that she had had a regular period five weeks prior to her death. Early on August 8, the patient had had heavy vaginal bleeding; the following morning her husband found her in bed unconscious and brought her to the emergency room. The pupils were dilated and fixed, and the pulse was imperceptible. Closed chest resuscitation was begun immediately and, through cutdowns, dextran and two units of blood were started, and a tracheotomy was performed. The electrocardiogram revealed no ventricular complexes; she was pronounced dead an hour after arrival, presumably due to vaginal bleeding with circulatory collapse.

Cause of Death (coroner's autopsy). Septic abortion with septicemia and myocardial abscess — *Clostridium perfringens;* induced abortion, manner undetermined, by persons unknown; pregnancy circa 1 to 2 months; intravascular hemolysis; hemoglobinuric nephrosis; pulmonary congestion and edema.

Comment

With facts few, the Committee studied available information. Members felt that somehow valiant therapeutic measures were wasted and superfluous, but the spirit to sustain survival of a *dead* person was laudable. This was voted a preventable maternal death, fault of the patient.

Case No. 1004

This patient was a 27-year-old Negro, gravida II, para I, who was admitted to the hospital on January 25 and died four days and 14 hours after admission. She was an unmarried registered nurse who had had one previous pregnancy. On this admission she was treated immediately for a *septic* abortion.

Her past history included hospitalization for arthritis, with no recurrance. One previous term pregnancy was uncomplicated. Her last period had been November 17 and she stated that she had decided to have an abortion because the father of the child suggested it to her and because of financial reasons. According to her statement on January 23, a physician had introduced a number 20 French catheter into the uterus. On the morning of admission to the hospital she began cramping and bleeding, expelled the catheter, became feverish with shaking chills and temperature 103.2F. White blood cell count (WBC) 10,300, 78 percent polys, 20 percent immature polys and 2 percent lymphocytes. The hemoglobin was 12 gm. per 100 ml. As her private physician was unable to obtain a bed at a private hospital, he sent her to the receiving ward. A cervical culture was taken on admission which grew a *Paracolon,* a nonhemolytic *Streptococcus* and *Proteus mirabilis.* A blood culture grew the same paracolon bacillus which proved to be sensitive to tetracycline, Chloromycetin, streptomycin, kanamycin and Furadantin but resistant to penicillin. Prothrombin time on admission was 57 percent of normal. Blood urea nitrogen (BUN) 15. mg. per 100 cc., carbon dioxide 15.5 mEq/liter and chloride 100 mEq/liter. Antibiotic therapy was begun with intravenous infusion of glucose in water with 10 million units of penicillin and one gram of Chloromycetin. Tetanus toxoid was given intramuscularly. By 6 PM, January 25, her temperature was 105F, her blood pressure began to drop, and she received Levophed infusion to a concentration of 6 ampules per 1,000 ccs. At this time she developed shortness of breath and the electrocardiogram was consistent with acute myocardial infarction. Hydrocortisone was added to the above therapy, the initial dose being 100 mg. She received apparently adequate consultation, but because of lack of response at 9 PM, the day after admission, a dilatation and curettage was done, producing very foul necrotic tissue. She was digitalized and kept on vasopressor medication. Kanamycin was added, 250 mg. every 12 hours, and she was given extra potassium parenterally. Urinary output remained good. Her Levin tube functioned well, but it was necessary to keep the vasopressor drug going at a fairly rapid rate to keep the blood pressure at 90 to 95 systolic and to assure adequate urinary output. Angiotensin had been given in addition to the Levophed, but she experienced a gradual drop of blood pressure and complained of upper gastric "tightness" and back pain.

The venous pressure indicated incipient congestive heart failure. In spite of the increased administration of Levophed, the patient's clinical condition deteriorated and she died at 9:30 PM, January 25.

Cause of Death (coroner's autopsy): Septic shock, septicemia (*paracolon intermedium,* non-hemolytic *streptococcus, Proteus mirabilis*); acute necrotizing endometritis and myometritis resulting from abortion; thrombosis of uterine veins; acute pulmonary edema; acute cerebral hyperemia, and petechia.

Comment

The Committee studied fascinating points in this case with appreciation of the amount of information available. Members agreed with the management of the patient's grave condition, including the dilatation and curettage, attempting to remove the original focus of the infection. However, although of little consequence, it was noted that the *dosage* of steroids was below the massive doses currently recommended. The Committee voted this a preventable maternal death, fault of the patient.

Comment of Consultant

The following comment of a consultant, who is a specialist in Obstetrics and Gynecology, was furnished at the request of the Committee.

This consultant studied facts in these three cases, also material in the previous article published on criminal abortion and septic shock.[3] In our opinion only one of the cases allows for much constructive or critical comment, beyond that already documented by the Committee, i.e., case 1004. However, a few preliminary observations may be made.

Case 617 died undelivered 19 hours after hospitalization, allowing relatively minimal time for evaluation and treatment. The fatal organism (*Clostridium perfringens*) was identified from cultures of (three) cervix, urine, and blood! Specific treatment was begun promptly, including (massive) antibiotics, fibrinogen, digitalis, and vasopressors.

In spite of this, the pathologic-physiologic mechanism included afibrinogenemia, intravascular hemolysis, pulmonary edema, irreversible shock with terminal myocardial failure, and death.

Case 766 was declared "D. O. A." We wondered WHO made the diagnosis the *first* time, since extensive therapy was instituted, then an

hour later (confirmed by EKG), she was pronounced "dead."

This is another result of the pathologic process induced by the introduction of *Clostridium perfringens*. But obviously, the physiologic mechanism had *progressed* further than the one mentioned above; *this* one involved the kidney in addition to the pulmonary and cardiac elements. Both patients developed intravascular hemolysis. In spite of all the heroic therapy in this case, only the *coroner* identified the fatal microorganism.

Case 1004. This patient survived 4½ days, thereby providing time for more systematic diagnosis and sophisticated treatment. The personnel very properly obtained cultures from (three) cervix, urine, and blood upon admission. Treatment was begun at once with *massive* doses of antibiotics. Here two different organisms were identified. One might critically assume that the dilatation and curettage should have been performed sooner, but obviously the patient was quite ill; and if 24 hours of therapy does not improve the patient's condition, the uterus is emptied or hysterectomy may be performed in selected cases.

It may be assumed that this patient was extremely sensitive to the invading microorganism and that the sepsis was, indeed, overwhelming. We agree with the Committee's comments.

McKay[4] was among the first to associate clinical changes of the Schwartzman reaction with those found in pregnant women who died after abruptio placentae and infection. The mechanism following introduction of virulent microorganisms into the genital tract of the pregnant female has undergone tremendous research.

An excellent treatise on the pathologic mechanics, diagnosis, and management of "puerperal shock" was published by Kramer.[5]

In summary we can reiterate: "In all cases of criminal (or septic) abortion, anticipate *septic shock*. (1) CERVIX, (2) urine, and (3) blood should be cultured (and stained) for identification of the invading microorganism. Anticipate the etiologic organism, if early identification is misleading. Stimulate renal function; give massive doses of antibiotics."

References

1. Committee on Maternal Health, OSMA: Maternal mortality report for Ohio; 10-year survey, 1955-1964. *Ohio State Med J* **63**:323-332, 1967.
2. Committee on Maternal Health, OSMA: Maternal mortality report for Ohio — 1965. *Ohio State Med J* **64**:1038-1041, 1968.
3. Committee on Maternal Health, OSMA: Maternal deaths with septic shock after criminal abortion. *Ohio State Med J* **65**:601-603, 1969.
4. McKay D: The generalized Shwartzman reaction in pregnant women. *Amer J Obstet Gynec* **20**:466, 1962.
5. Kramer Charles F: Puerperal shock. *Int Surg* **50**:44-64, 1968.

FOREWARNING RINGS DOWN THE CORRIDORS OF TIME.—The following is a passage extracted from an article written for the Dalhousie University Year Book in 1932 by a senior student in the Medical School, who is now a Cleveland physician.

"In the years to come there will probably be increasing public dissatisfaction with the organization of medical service. Something will have to be done to divide the cost of medical care more evenly. In some places we already see a change and the drift is very often towards state medicine. The majority of our doctors look upon this solution with disfavor. Another possible course is the institution of "medical guilds." Membership would be open to the public on payment of regular dues, on the principles of insurance. The guild would guarantee to provide medical care and hospital service for its members when necessary. As in the case of insurance, the dues would have to be paid whether service were actually rendered or not.

"Now is the time for medical men to consider these matters. If they fail to find a solution, the people, or the government, may find one which will be very unsatisfactory to the profession."—John H. Budd, M.D.



Professional Activities

Proceedings of the Council

Meeting of April 18-19, 1970

A REGULAR MEETING of The Council of the Ohio State Medical Association was held Saturday and Sunday, April 18-19, 1970, at the OSMA Headquarters' office, 17 S. High Street, Columbus.

All members of The Council, with the exception of Dr. Oscar W. Clarke, were present on Saturday, April 18. Others attending the meeting were: Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Dr. John H. Budd, Cleveland, Chairman of the Ohio Delegation to the American Medical Association; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Price and Moore of the headquarters' office staff.

Those present Sunday, April 19, were: All members of The Council, with the exception of Drs. George J. Schroer and Oscar W. Clarke. Others attending the meeting were: Mr. Stichter; Mr. James S. Imboden, Columbus, AMA Field Representative; Dr. Budd; Dr. Thomas E. Shaffer, Columbus, and Dr. Sol Maggied, West Jefferson, representing the OSMA Joint Advisory Committee on Athletic Injuries; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, Price and Moore of the headquarters' office staff.

Minutes Approved

Minutes of the meeting held February 21-22, 1970, **were approved** by official action.

Amendments to Bylaws

Amendments to the Hancock County Medical Society Articles of Incorporation and its Code of Regulations (consisting of the Constitution and Bylaws) **were approved.**

American Medical Association

Dr. Budd reported on developments in connection with the American Medical Association meeting, scheduled for June 21-25, in Chicago.

Minutes of a meeting of the Ohio Delegation to the AMA, held March 15, 1970, were presented by Dr. Budd and **were approved.** Approval of the minutes included approval of a resolution in support of the Ad Hoc Committee Report on Long-Range Planning, which will be offered by the Ohio Delegation at the AMA meeting.

Ohio Medical Indemnity, Inc.

NABSP Meeting

Drs. Light, Smith, Wells and Ivins reported on the meeting of the National Association of Blue Shield Plans, which was held in Miami, April 3-6, 1970.

Prime Contractor Letter

A letter dated February 2, 1970, from John W. Castellucci, President of the National Association of Blue Shield Plans, to Ernest B. Howard,

M.D., Executive Vice President of the American Medical Association, concerning NABSP's plans to become "prime contractor" for government programs, was presented to The Council.

OMI 25th Anniversary

The Council adopted the following congratulatory message in connection with the celebration of Ohio Medical Indemnity's 25th Anniversary on April 24, 1970:

> "At the meeting of The Council of the Ohio State Medical Association on 18 April 1970, it was unanimously voted to extend to the Ohio Medical Indemnity, sincere congratulations and commendation for the achievement of Twenty-Five Years of steadfast adherence to the original premise of the Founding Fathers and for the exemplary conduct of this business with such capable and secure administration. The Ohio State Medical Association looks forward to the continued success of the Ohio Medical Indemnity and continued devotion to the public."

The Council voted to present a similar statement to the OSMA House of Delegates.

OMI Code of Regulations

The Council **approved** the amending of the Code of Regulations of Ohio Medical Indemnity, Inc. so as to eliminate the requirement that the President of OMI be a member of the Board of Directors and thus permit the Board of Directors of OMI to promote Mr. Coghlan, the Executive Vice President, to the office of President of OMI. Mr. Stichter was, accordingly, authorized to draft the appropriate amendments to the Code of Regulations required to effectuate this change.

Committee Reports

Athletic Injuries

Mr. Clinger presented the report of the Joint Advisory Committee on Athletic Injuries' meeting of March 1, 1970. It was **accepted** for information.

Dr. Sol Maggied and Dr. Thomas E. Shaffer presented the report of the meeting of the Joint Advisory Committee on Athletic Injuries on April 1, 1970. Following the discussion, the Council **approved** the 11 recommendations of the report, which were as follows:

> "1. **A mandatory requirement** that water be available — on the field — at all times during practice sessions and games involving Ohio junior high school, junior varsity, reserve and high school football teams.
>
> "2. **A mandatory requirement** that a coach be present throughout all practice sessions for Ohio junior high school, junior varsity, reserve and high school football teams.
>
> "3. **A mandatory requirement** that fall football practice will begin on the Monday preceding the Friday three weeks before the opening game. The first four days of practice (Monday through Thursday) shall be devoted to conditioning. There will be no contact and no pads will be worn during the four-day conditioning period. Shoes and headgear will be permitted.
>
> "4. **A mandatory requirement** that the weight chart prepared by the Committee and distributed to all schools by the Ohio High School Athletic Association be used until the beginning of the regular season — and that a manager or other assistant associated with each team be designated to record the necessary information. Completed forms should be available for the OHSAA Commissioner anytime from start of fall practice to conclusion of the season.
>
> "5. **A mandatory requirement** that a 10 to 15-minute session on sports medicine — with emphasis on heat — be presented by a physician at each pre-season rules interpretation meeting conducted by the Ohio High School Athletic Association. Physician members of the Joint Advisory Committee on Athletic Injuries will be asked to make the presentation at rules interpretation meetings held in their respective areas. (Attendance at a rules interpretation meeting is already **mandatory** for at least one member from the football coaching staff of each high school in Ohio). The Subcommittee believes that these presentations would strengthen physician-coach rapport at the local level.
>
> "6. Reaffirmation of the resolution passed by the 1962 OSMA House of Delegates that a physician be present at all Ohio high school athletic body-contact contests. The Subcommittee further recommends that an emergency squad also be available at all junior high, junior varsity, reserve and high school games.
>
> "7. Development of councilor district/or regional meetings on sports medicine — similar to those currently held in Butler County and Jefferson County — for physicians, coaches, trainers and school administrators.
>
> "8. Reaffirmation of previous recom-

mendations that all schools have a qualified trainer.

"9. Revisions in the conduct of practice sessions — on the basis of medical considerations — when environmental conditions, mainly the temperature — humidity factor, become critical. Revisions would be in the following areas:

a. Length of practice;

b. Time of day (for example, when weather is hot and humid, practice would be changed to early morning and sundown);

c. Type and amount of clothing and equipment (for example, use of mesh jersies, shorts, etc.);

d. Degree of exertion (for example, less intense running as the temperature — humidity factor climbs).

"10. That the name of the Committee be changed from the Joint Advisory Committee on Athletic Injuries to the **Joint Advisory Committee on Sports Medicine** of OSMA and the OHSAA.

"11. That a Section on Sports Medicine be formed as a Scientific Section of the Ohio State Medical Association."

School Bus Driver Examinations

The minutes of the Joint Committee on School Bus Driver Examinations, April 15, 1970, were presented by Mr. Clinger. The Council re-referred the recommendations to the Committee, with the suggestion that where disqualifications apply to heart surgery, brain surgery and diabetes, that provisions be made to permit some latitude for exception.

Private Practice

Dr. Lieber presented the report of the minutes of the Committee on Private Practice, March 18, 1970. The Council **approved** the recommendations of the Committee, that all reports prepared by the OSMA Department of Medical Economics, which are appropriate, be supplied to all members of the Committee on Private Practice.

Also **approved** was a survey of all Ohio hospitals to determine how many have training programs, how many have full-time medical educators (directors of medical education), and how many salaried, hospital based physicians they have.

It was agreed that Dr. Lieber would be a liaison representative to the Commission on Medical Education of the Ohio State Medical Association and that Dr. Robert E. Zipf would be liaison representative from the Commission on Medical Education to the Committee on Private Practice. The minutes, as a whole, **were accepted.**

Membership and Planning

Dr. Schultz presented a progress report on the Membership and Planning Survey. The Council voted its thanks to Mr. Charles H. Coghlan, and Ohio Medical Indemnity, Inc., for their cooperation in the survey. Items of the survey were referred to OSMA Committees as follows:

Committee on Education — Questions #1, 2, 3, 9 and 16.

Committee on Scientific Work — Questions #4, 6 and 8.

Committee on Public Relations — Questions #16 and 18.

Council and Staff — Question #7.

Committee on Peer Review — Questions #14 and 15.

Dr. Schultz announced that a summary of the survey would appear in the May issue of *The Ohio State Medical Journal.*

Peer Review

The report of the Committee on Peer Review was presented by Dr. Henry. The report was **amended and approved** as OSMA guidelines for utilization review. The text of the report is carried on page 601 of this issue of *The Ohio State Medical Journal.*

Fee Review

Dr. Ivins reported for the Committee on Fee Review. The Council **approved** the following fee review procedure:

OSMA Fee Review Procedure

"I. Criterion for initiating the fee review mechanism is a written statement from patient or third party stating that attempts to arrive at an agreeable settlement with the physician have failed.

"II. The physician is then notified that his fee has been questioned, and that the case has been referred through the OSMA district councilor to his local medical society for review and evaluation.

"III. In those situations where the local medical society refuses to review such cases or where an amicable solution has not been reached by the concerned parties at the local level, the Council Fee Review Committee will consider the case.

"IV. The physician is notified the Council Fee Review Committee is considering his case.

"V. Efforts should be made through discussions with the physician and the com-



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Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

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Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

*References available on request.

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942

Research in the Service of Medicine



Owner Breaks Arm When Yacht Runs Agrou

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] large rock tially capsized. The fire dep had to rescue Waters by sm Damage to the yacht is estir

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The compound analgesic that calms instead of caffeinate

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mittee to resolve the problem on an informal basis.

"VI. If informal discussions are not successful, a committee meeting is called. The physician is to be notified at least 14 days prior to the meeting so that he can be present to defend his position with information he considers material and proper.

"VII. The findings and recommendations of the Council Fee Review Committee are forwarded to the Council for final action.

"VIII. The Council notifies the concerned parties of its action."

Four cases were presented by the Fee Review Committee. The Council voted to **accept** the recommendations of the Committee in each of the four cases presented.

Rural Health

Mr. Clinger presented a report of the Committee on Rural Health. The Council voted to **approve** the recommendations of the report, namely:

"1. That the Committee on Rural Health sponsor, for elective credit by Ohio's medical colleges, a physician-oriented **Senior Clerkship In Community Medicine.**

"2. That OSMA sanction and give administrative support, upon request, to a summer program of clinical fellowships in community hospitals sponsored by the Student American Medical Association for **pre-freshmen** and **freshmen** medical students."

Education

Mr. Edgar presented minutes of the Commission on Education meeting of April 1, 1970. Council **approved** the Commission's recommendation that a statewide conference on the physician's assistant be sponsored by the Ohio State Medical Association. It was requested that a tentative program be submitted to it in advance.

State Legislation

The Council ratified the decision of the officers not to oppose H.B. 707, which requires chiropractors to register with the Ohio State Medical Board every two years. It was indicated that this legislation will enable the Medical Board to identify and locate those chiropractors operating in Ohio and thus contribute to a better enforcement program.

The Council also ratified the decision of the officers on H.B. 874, the omnibus drug bill. The decision had to do with permitting a 16-year old, who is mentally ill by reason of drug abuse, to apply for voluntary admission to a public or private hospital. It would also permit 16-year olds and older to establish the physician-patient relationship and consent in their own behalf to treatment for drug problems or complications of drug problems. A section requiring physicians to report persons seeking drug treatment to the enforcement authorities was deleted from the bill at OSMA's request and by the request of other organizations.

Federal Legislation

Mr. Edgar reported on developments in the House Ways and Means Committee of Congress, with regard to attempts to add chiropractic to Medicare and with regard to attempts to enact a "Part C" to Medicare legislation.

Midwest Journal Proposal

A communication from Mr. Edward F. Willenborg, Executive Secretary of the Academy of Medicine of Cincinnati, regarding a proposal for a Midwest Medical Journal, was **accepted** for information and for study by the Council in its continuous evaluation of *The Ohio State Medical Journal.*

Dues Exemption Proposal

The Council took up, for consideration, a communication from Mr. Edward F. Willenborg, which proposed that Council study the effect of an automatic dues exemption on the part of the Ohio State Medical Association to be given to members as an option upon reaching age 70. It was brought to the attention of The Council that a resolution of the 1964 House of Delegates asked that such a proposal be presented in 1965. At the 1965 Annual Meeting, the House defeated the measure on the grounds "that it is the philosophy of this Association that need rather than age be a criterion for eligibility for such a benefit." The Council referred the matter to the Auditing and Appropriations Committee for study with regard to its possible effect on the fiscal operation of the Association.

Ohio Public Health Association

In answer to a request, The Council voted a $25 sustaining membership in the Ohio Public Health Association.

AMA-ERF Contributions

Council considered a communication from Mr. Robert A. Lang, Executive Secretary of the Academy of Medicine of Cleveland, proposing that amounts paid to the Ohio State Medical Association by the American Medical Association for the collection of AMA dues, amounting to one per cent of total AMA dues paid, be distributed direct to the county medical societies rather

than being contributed to the American Medical Association Education and Research Foundation in the name of the larger counties individually and the smaller county medical societies collectively. After a discussion of the matter at hand, Council voted to continue the present method of distribution of these funds.

Medical Benevolent Association

The Council voted to authorize the Treasurer to proceed with the dissolution of the Ohio Medical Benevolent Association.

Nurse-Administered Anesthesia

Council took up, for study, a communication from Dr. R. B. Larrick, Columbus, with regard to nurse-administered anesthesia. After discussion of the matter, it was agreed that the communication be referred to the Ohio Society of Anesthesiologists and its Columbus affiliate, asking for comments and offering to meet with them concerning the communication.

Radiologic Technicians

A communication from Dr. William B. Schwartz, Columbus, with regard to radiologic technicians was presented to the Council.

The Council referred to Mr. Stichter the preparation of a legal opinion on the questions posed by Dr. Schwartz.

Offices in Hospitals

A communication from Dr. Myron H. Powelson, Zanesville, with regard to hospitals renting private offices to physicians was discussed by The Council and the matter was referred to Dr. William M. Wells, Eighth District Councilor.

Reorganization of Health Agencies

The Council discussed a memorandum from Dr. H. William Porterfield, Columbus, with regard to House of Delegates' Resolution 22-68, "Reorganization of Health Agencies." The Council agreed with Dr. Porterfield that candidates for legislative offices be asked to express their views on the reorganization of health agencies prior to the November elections.

Malpractice Report

A proposed report on medical malpractice was presented by Jerry J. Campbell. It was **approved** for transmittal to the House of Delegates.

Socio-Economics Conference

A proposal for an Ohio Medical Socio-Economics Conference, from Dr. Edward O. Hahn, Youngstown, President of the Ohio Society of Internal Medicine, was discussed by The Council. The matter was referred to Mr. Charles F. Price for study and development.

Group Auto Leasing

Council authorized the following committee to proceed to explore the possibilities of group auto leasing by the OSMA: the President, the President-Elect, Past President and Treasurer.

Section on Neurology

In answer to a request from Thomas W. Wallace, M.D., Cleveland, representing neurologists throughout the state, the Council **approved** the establishment of a Section on Neurology of the Ohio State Medical Association.

Report on 1969 House Resolutions

The Executive Secretary presented a report to the OSMA House of Delegates on the "follow-up" work on 1969 resolutions passed by the House and which called for organizational action. The Council **accepted** the report for transmittal to the House and requested that the format of this report become standard operating procedure in future years.

Appreciation to Dr. Theodore L. Light

Council **adopted** a resolution of appreciation to Dr. Theodore L. Light for his many years of devotion and dedication as Councilor, as President-Elect, as President, as Past President, and as a Delegate to the American Medical Association. Dr. Light extended to the Council his thanks and appreciation for the opportunity to participate in the activities of the Ohio State Medical Association.

Congratulations to Dr. Smith

The Council **adopted** a resolution expressing sincere congratulations to Dr. Robert N. Smith for his accomplishments as President of the Association. Dr. Smith expressed to the members of Council his appreciation for their dedication and their thoughtfulness.

Greetings to Miss Winzenried

By official action, the Council voted to send greetings to Miss Hazel M. Winzenried and best wishes for a speedy recovery. Miss Winzenried, a long time member of the OSMA staff, is a surgical patient at Mount Carmel Hospital.

There being no further business, The Council adjourned, setting 8:00 a.m. Friday, May 15, as the time and date of the next meeting.

ATTEST: HART F. PAGE
Executive Secretary

Utilization Review

Standard Utilization Program Adaptable to All General Hospitals

THE COUNCIL of the Ohio State Medical Association, at its meeting on April 18-19, 1970 adopted the following text as guidelines for effective standard utilization programs. The standard utilization program adaptable to all general hospitals was prepared by the Committee on Peer Review, consisting of Dr. James L. Henry, Dr. Robert N. Smith, and Dr. Richard L. Fulton.

Foreword

The Utilization Review Committee is established in recognition of the necessity for continuous surveillance and critique of all phases of hospital activity, including the admission, care and discharge of all patients as well as the manifold personal relationships and functions relating thereto. These are *must* responsibilities of all categorical professional and administrative levels within this hospital.

The Utilization Review Committee is a fact-finding, educational instrument of the medical staff. This committee has no authority to effect, directly, changes in procedure and policy, nor can it lessen the responsibilities or privileges of individual staff members, staff committees, administrative personnel and department chairman (where applicable).

It is the duty of the Utilization Review Committee to assure all inpatient services rendered in this hospital are necessary and could not have been provided as effectively in the home, outpatient facility or another appropriate facility. This committee must responsibly analyze and identify the factors which contribute to unnecessary, unjustified and ineffective utilization of existing inpatient services by a medical staff, nursing service, and other hospital personnel. These facts and appropriate recommendations must be submitted to the medical staff and administrative authorities.

The Utilization Review Committee must be established in the medical staff bylaws. These bylaws must provide that voting members of the committee are to be medical staff members only. A properly constituted and organized utilization review program fulfills all governmental and accreditation requirements as well as providing a method for achieving proper utilization of hospital beds and inpatient services.

Membership

The membership of the Utilization Review Committee should be limited, insofar as possible, to staff physicians engaged in the active practice of medicine. All disciplines of medicine should be represented on this committee whenever it is practical. Any member of the medical staff may serve on the committee, but special attention should be given to assure representation from physicians, where available, engaged in the practice of Obstetrics-Gynecology, Surgery, Internal Medicine, Orthopedics, General Medicine, and Psychiatry and Ophthalmology.

The Committee should be authorized to procure the counsel and advice of representatives from Radiology, Pathology, Social Services, Nursing Service, and Medical Records. These individuals should serve in an ex officio capacity to the physician-oriented utilization review committee.

Membership to this committee should be made by the medical staff structure with the knowledge (and consent) of the hospital administration and governing body. Appointments should be made on the recommendations of department chairmen or appropriate staff representatives.

Appointments to this committee should be carefully supervised to assure that membership is exclusively physician oriented.

Tenure on this committee should be relatively limited to insure that the entire staff has the opportunity to serve. A term of not less than one nor more than three years would be satisfactory. The exception to this would be the tenure of the chairman. Provisions for continuity of committee leadership is essential.

Meetings

The Utilization Review Committee shall meet at least once each month or more often at the discretion of the chairman. Individual committee members may be required to function at the request of the committee chairman to eval-

uate patient overstays and to submit professional opinions for consideration.

Functions

The Utilization Review Committee in order to discharge its fullest responsibility, must assure that all inpatient service given is necessary and justified. In accomplishing this, all of the following functions must be performed:

1. Study of over-utilization of hospital stay.

2. Study of cases of under-utilization of hospital stay.

3. Determine the necessity of hospital admissions.

4. Identify and eliminate reasons for delays and/or overuse of ordered services.

5. Study causes for delays in consultations and referrals—resulting in prolonged patient stay.

Conclusions of these studies should be summarized along with recommendations pertinent to problem areas identified.

Current Inpatient Evaluation Functions

1. Assure that **all** hospital admissions are attested by an adequate history and physical or by an admission note on the progress records.

2. Assure that all inpatient charts have meaningful progress notes which establish the medical necessity for continuing stay and documents the physician's professional appraisal of the patient's condition and his opinion of the anticipated length of stay. The time interval between progress notes should not exceed six days.

3. Assure that all required certifications are accomplished by means of an identifiable progress note. Such a note by the attending physician must demonstrate the need for continued hospitalization and/or plans for disposition of the case.

4. Evaluate all inpatient charts to determine whether or not continued stay is necessary. In order to accomplish this, evaluation shall be based upon the **anticipated length of stay by disease entity.** The need for continued hospitalization and medical justification for such stay must be noted when a patient's hospital stay exceeds the anticipated stay by 20 percent. Reviews based on length of stay concept will automatically cause evaluation of all recertifications. Each hospital admission chart will have an anticipated length of stay work sheet attached so that all concerned will be informed of the date that medical attestments for continued stay are required. (Median or anticipated lengths of stay can be obtained from medical records department or from several professional data collection systems such as PAS, HUP and others. Lengths of stay by disease entity should be acceptable to and approved by the medical staff of this hospital before such data are used.)

5. Conduct a monthly review of all understay-overstay or extended duration cases as reported to the committee.

6. Institute a procedure for notifying individual physicians that he must fulfill specific requirements of the committee. (Progress notes, recertifications and documentations justifying length of stay are examples.)

7. Conduct a retrospective evaluation of patient care afforded in this hospital. Studies must include all extended duration (overstay) cases as well as cases of under-utilization. An indepth survey of a specific disease category and/or operative procedure must be conducted regularly. Charts deemed inadequate or incomplete by the medical record librarian must be reviewed routinely. This function may be performed by the Utilization Review Committee, but it may be more appropriate to assign this responsibility to a subcommittee or another properly constituted committee of the staff.

8. Assure that patient, physician and administration are notified when determination has been made that the level of care needed by the patient does not require further hospitalization. Upon such notification, the patient should be discharged by the attending physician unless, in 3 days, he has justified need for extended hospitalization.

9. Employ, with hospital administration, an experienced and qualified person, preferrably a registered nurse, to perform as functioning secretary of the Utilization Review Committee. The committee shall establish guidelines and policy for the secretary, who must in turn be responsible to the committee.

10. Transmit the monthly minutes, recommendations and actions of the Utilization Review Committee to both the hospital administrator and the appropriate staff officers and committees.

11. Assure that committee members will not be permitted to review a case in which

they have professional involvement. Physicians having ownership rights in this hospital shall not serve on the committee.

Utilization Secretary Functions

1. Survey charts of all admissions to determine the admitting diagnosis and reasons for admission as noted by the attending physician.

2. Assign the anticipated length of stay, from predetermined data, for the disease entity or entities. At this time, the review data shall be inserted for the information of both the physician and the committee.

3. Review all charts to be certain that the required medical information has been inscribed. If deficiencies in the chart are determined, the secretary must note such deficiencies for the attention of the physician. Continued and persistent record deficiencies must be reported to the chairman of the Utilization Review Committee.

4. Must report, after appropriate council with the Utilization Review Committee chairman or his designee, cases in which the admission is questionable; recertification has not been accomplished; and cases in which the maximum level of care may no longer be required.

5. Must re-survey and report to the Utilization Review Committee all inpatients who have reached a stay 20 percent beyond the anticipated length of stay for the particular disease entity.

6. Act as liaison agent between Social Service and the attending physician to facilitate the timely discharge of patients to an appropriate facility, or agency such as an extended care facility.

7. Attends meetings of the Utilization Review Committee with the necessary records to properly conduct the affairs of the committee.

8. Collects and maintains all minutes and records necessary to the effective operation of the committee.

9. In summary, the Utilization Review Committee secretary is responsible to the committee for facilitating chart reviews; maintaining committee records; minutes, assembling required information; exploring methods for procedural improvements; and promoting the most efficient use of all available health reviews and facilities.

Function of Lay Secretary to Utilization Review Committee:

(Such an employee of the committee may be required when the patient volume dictates a heavy load of secretarial skill.)

1. Assist and be responsible to the Utilization Review Committee secretary and to the committee chairman.

2. Responsible for the distribution of communications between the Utilization Review Committee and the hospital staff. Insure that the medical staff receives all reports pertinent to utilization review.

3. Transmits to patient (or family), attending physician, and the proper administrative officer a forty-eight hour written notice that medicare benefits have been terminated. (Required by federal regulation.)

4. Maintains an accurate summary of the monthly records of the inpatients and actions taken by the committee relative to these patients.

Records Necessary to Effective Operation of Utilization Review Committee:

1. Minutes of meetings of the Utilization Review Committee and any associated or allied committee. These minutes must include the number of cases reviewed and on file.

2. Lengths of stay records on **all** cases of overstay (extended duration) must be maintained on file for at least one year.

3. Monthly reports of all extended duration cases (anticipated stay plus 20 percent) must be maintained. Individual patients may be identified by code only and not by name.

4. Copies of letters of termination of benefits must be kept on file.

5. Records maintained for requirements must include:

a. Total number of patients as well as total number of medicare patients admitted each month.

b. Total number of patients reviewed by the committee.

c. Total number of cases of extended duration (length of stay plus 20 percent).

d. Total number of patients qualified for recertification during a given month.

Records and minutes of the Utilization Review Committee must be made available to the third party carriers or intermediaries. Such organizations are entitled to only such portions of the records as may be cogent to their requirements. Records of all patients are not cogent, only those records that apply to involved patients may be made available. This restriction applies equally to representatives of the several governmental agencies.

Ohio Physician Named President of Federation of State Medical Boards

NATIONAL HONORS were accorded an Ohio physician when Dr. Frederick T. Merchant, of Marion, was named President of the Federation of State Medical Boards of the United States, Inc. The Federation, as its name implies, is comprised of representatives of medical licensing boards of the 50 states, the District of Columbia, and U. S. territories.

In addition to his involvement in the medical licensure program on the state and national level, Dr. Merchant has made outstanding contributions to medical organization work. He is a past president of the Marion Academy of Medicine, represented Marion County in the Ohio State Medical Association House of Delegates, and served on The OSMA Council as Councilor of the Third District. Also on the state level he served on the OSMA Judicial and Professional Relations Committee, the Committee on Hospital Relations, and the Committee on Scientific Works.

A fitting tribute to his professional achievements appeared in the April issue of the *Federation Bulletin,* official publication of the Federation of State Medical Boards of the U. S. It is quoted in its entirety as follows:

FREDERICK T. MERCHANT, M.D. IS 56th PRESIDENT OF FEDERATION

To regular observers of the Fred Merchant *phenomenon,* whether their vantage point has been within the board of directors, the Examination Institute Committee or the board varied general membership of the Federation, the announcement that Fred now is president of the organization is no surprise—and might not be considered as "news." Those with knowledge of the breadth of his involvement in his hospital, his local and state medical associations, and civic and political affairs, long have recognized his innate vigor, enthusiasm and intensity of purpose. His leadership ability, an asset which surfaces early within almost any group in which he becomes more than superficially involved made the Federation presidency an inevitable conclusion.

The editor of the BULLETIN has been an observer of the *phenomenon* from the vantage points noted above as well as several others not so identified. Although Fred had attended annual meetings for a number of years, his involvement in Federation affairs in depth began one fateful day-after-Columbus Day in Chicago. There the Examination Institute Committee (including the editor) met and began to make plans for the conception of what has become the now-robust FLEX (Federation Licensing Examination). Such an examination development program became a personal challenge to Fred, as it was to the other members of the committee that functioned harmoniously for several years. None will question



Dr. Merchant

that his enthusiastic leadership, particularly in recent years as general chairman of FLEX, has been a paramount factor in the current degree of success of the Federation Licensing Examination. Only those close to the program before the conception of FLEX can know the hours of time and energy he has expended in his effort to achieve success for the examination.

Solving problems in examinations and other facets of medical licensure has not been a lifelong task for Fred Merchant, for he first became a member of the Ohio State Medical Board in 1957. For three of the twelve years, 1957-1969, he served as president of the board, and he continues as a board member. Nominated by the Federation as a representative to the board of the National Board of Medical Examiners, soon he was elected to the executive committee of the National Board and yet continues in that capacity.

Born in Marion, Ohio, he graduated from Ohio Wesleyan University (Phi Beta Kappa) and gained his medical degree at Johns Hopkins School of Medicine. Initial hospital-based post-M.D. training was at the Johns Hopkins Hospital, but the following year was devoted to pathology at Royal Victoria Hospital and McGill University Faculty of Medicine, Montreal, Quebec. An interim residency in surgery at the University Hos-

pitals of Cleveland was followed by two years as resident surgeon at the Royal Victoria Hospital.

During four years of military service he advanced to the rank of Lt. Colonel, and he was chief of a leading surgical team. Subsequently, he returned to Marion, Ohio and launched his practice of general surgery in 1946. During the Korean Conflict, in 1950-51, he was assigned to the office of the Surgeon General, Department of the Army, where he served as assistant chief of the surgical consultants division.

Certified as a Diplomate by the American Board of Surgery in 1946, he became a Fellow of the American College of Surgeons the following year. His professional memberships, otherwise, are many in number, to a great extent related to his chosen field of surgery. Citations and awards given him by his peers within the profession have been numerous. In addition, he has been rewarded and widely recognized for his generosity with his time and talent in civic activities throughout his state.

A member of Phi Gamma Delta at Ohio Wesleyan and Nu Sigma Nu at Johns Hopkins, Fred has been a member of several fraternal and service organizations, including the Rotary Club of Marion, Ohio. Long an active member of his church, he continues his community service there as his time allows.

When his burning interest in the problems of medical licensure was still of limited proportions, he was serving as a member of the Council of the Ohio State Medical Association. He had worked within and had led a number of important committees of the OSMA and his talent for leadership had become obvious to many within the association. However, when his term as councilor terminated in 1968, Fred Merchant withdrew himself from consideration for higher office within the OSMA. Those familiar with the Federation Licensing Examination will realize that 1968 was the year that FLEX, yet an infant, began to demonstrate its potential vigor, and it must have been obvious that he couldn't handle additional responsibility effectively because of the burgeoning examination program.

The Federation is proud of the former achievements of its president — before he became enamoured of its programs but even more so since he has demonstrated his vigor, enthusiasm and intensity of purpose in programs of the utmost importance, in the very life-blood areas of Federation activities. As president of the Federation of State Medical Boards of the United States, it is expected that Frederick T. Merchant's noted characteristics and talent will carry the organization much further than "just another mile" along the way. However, members must realize that each of us has a limit to his capacity—and that only through membership response to the suggestions and requests of the president can the Federation possibly "keep up" with its leader's expectations.

Following his inauguration, the new president of the Federation spoke of the several challenges now facing medical licensure — and, in particular, the Federation. In his brief remarks he emphasized the need to face the challenges of doubt from the more youthful members of the profession, many of them yet engrossed in their basic medical education. As the often-youthful members press forward, questioning the established systems of examination and licensure, Dr. Merchant cautioned the members of the need to become more *progressive*. Merely being aware that the forces threatening medical licensure systems exist is not enough, he indicated. The very survival of the state medical board system can depend upon how rapidly progress can replace the attitude of resistance to change that has permeated many levels of medical licensure.

In introducing the new president, Dr. P. T. Lamey described Fred Merchant as a man of great integrity, vigor and ability. Significantly, these are the very characteristics that all observers, wherever their vantage point might be, credited to the success of the Fred Merchant *phenomenon*. What more could *the* Federation actually *any* federation, ask their president to be? At the helm, throughout the year, all will recognize the presence of a firm hand!

Cincinnati Researchers Study Neutron Implantations

The radiology and nuclear engineering departments of the University of Cincinnati are pooling knowledge to study the radiation dose associated with implanting neutron sources in the human body as a substitute for radium in the treatment of cancer. These neutron sources are from Californium 252.

Dr. James G. Keriakes, professor of radiology, and Assistant Professor Alvin Shapiro, of the nuclear engineering department have been awarded a research grant from the James Picker Foundation on recommendation of the committee on radiology, National Academy of Sciences — National Research Council to further their joint research.

Continuing Education Opportunities for Physicians in Ohio

June

One Week Physician Course—Nuclear Medicine — June 8-13; Contact: D. Bruce Sodee, M.D., Director, Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124.

Medical Seminars — Youngstown Hospital Association, South Unit, Mondays, 4:00 p.m.; June 8 — "Fungal Infections of the Skin," Drs. K. Lloyd and B. Thimmappa; June 22 — "Diabetic Neuropathy," Drs. L. Green and W. Tsang.

Second Annual Urologic Outing on Controversies in Urology — Sponsored by The Ohio State University Division of Urology at Burr Oak State Park, Ohio, on June 29, 30, and July 1. Modern, air-conditioned facilities. Please contact Program Director Chester C. Winter, M.D., Division of Urology, Ohio State University Medical Center, 410 W. 10th Avenue, Columbus 43210.

August

Ohio Academy of General Practice, Annual Assembly, August 4-6, Sheraton-Columbus Motor Hotel, downtown Columbus; contact the OAGP.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

September

Eleventh Annual Pediatric Postgraduate Conference sponsored by OSU College of Medicine, Department of Pediatrics, and the Columbus Children's Hospital, September 24-25; Contact Center for Continuing Medical Education, OSU College of Medicine, 320 W. Tenth Ave., Columbus 43210.

Ohio Chapter, American College of Surgeons, Neil House Motor Hotel, Columbus, September 25-26; Charles G. Livingood, M.D., Secretary, 211 S. Main Street, Dayton 45402.

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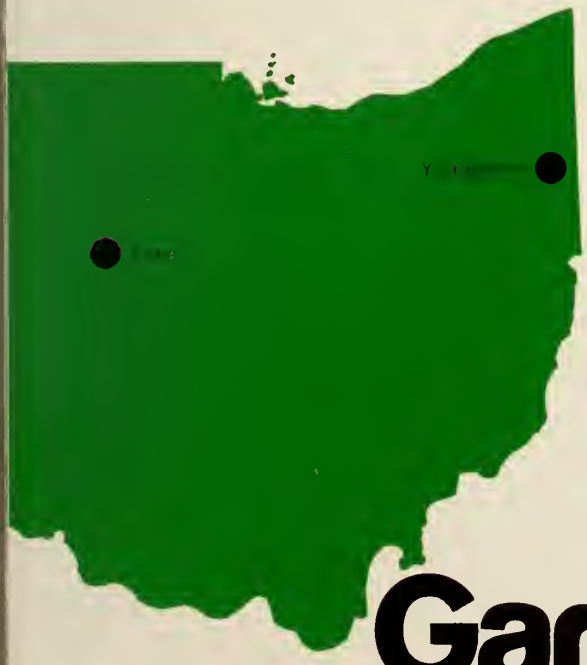
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brand of
gentamicin sulfate
injection

n estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Youngstown and Lima is 203,000.
Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

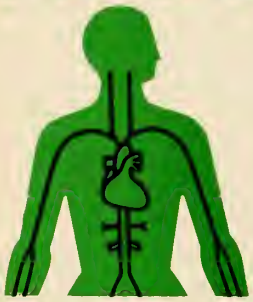
GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus*, coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus*, unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[6] Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.

Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.

Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.

It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of
gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®
brand of gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover, may result in additive toxicity. Monitoring of vestibular, cochlear and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, Arch. Int. Med. *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in Gentamicin: First International Symposium, Paris, January 1967, Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. (6) Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H.: Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

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GP Scientific Assembly

Columbus, August 4-6

THE ANNUAL SCIENTIFIC ASSEMBLY of the Ohio Academy of General Practice will be held at the Sheraton-Columbus Motor Hotel, with the scientific features of the program scheduled on Tuesday-Thursday, August 4-6.

The Theme is "Progress for You—Something Old, Something New." The program is acceptable by the American Academy of General Practice for 12 prescribed hours. Exhibits will be featured at the meeting.

The House of Delegates will meet on Monday, August 3, beginning at 4:00 p.m., and again on Tuesday morning.

The program has been announced as follows:

Tuesday Afternoon, August 4

Welcome Addresses

Comprehensive Review of Brain Dysfunction

Introduction of the Subject—Joseph G. Peil, M.D., Middletown

Diagnosis and Treatment of the Badly Brain Damaged Child—Rosalie Wilkinson, M.D., Philadelphia

Diagnosis and Treatment of Learning Disabilities—Evan Thomas, M.D., Philadelphia

Questions and Answers with a Panel of the Foregoing Speakers

Tuesday Evening

Social Hour and Banquet

Wednesday Morning, August 5

Current Diagnostic and Therapeutic Approaches to Peripheral Arterial Occlusive Disease—Film by R. E. Fremont, M.D.

Office Management of Foot Problems—Management of Infant Foot Disorders—Dr. J. V. Ganley, Podiatrist, Norristown, Pa.

Questions and Answers

Early Recognition of Rheumatic Disorders of the Younger Years—Rodney J. McKenzie, M.D., Cincinnati

Question and Answer Session

Wednesday Afternoon

Office Prevention and Control of Atherosclerosis

Role of Exercise,—Who, What, Where?—Herman K. Hellerstein, M.D., Cleveland

Questions and Answers

A Horrible Menu in an Affluent Society—Frederick A. Kruger, M.D., Columbus

Question and Answer Session

Wednesday Evening

Marion Laboratories Party

Thursday Morning, August 6

Recent Advances in Diagnosis and Treatment of Angina Pectoris—Film by Richard Gorlin, M.D.

Multiple Office Procedures

Hearing Conservation in Industry—Marion T. Summar, M.D., Virginia, Minn.

Vertigo and Dizziness—Claude P. Hobeika, M.D., Cincinnati

What's New in Antibiotics—Samuel Saslaw, M.D., Columbus

What's New in Immunizations—Henry G. Cramblett, M.D., Columbus

Question and Answer Session

Thursday Afternoon

Special Session Covering Drugs and Narcotics
Registration Fee $10—Acceptable for three AAGP Credit Hours

Don't Blow Your Mind

The Role of the State Investigative Agency for Narcotics and Dangerous Drug Control—Albert D. Cook, Chief, Division of Narcotics and Dangerous Drugs

Drug Abuse and Drug Dependence—Rupert Salisbury, OSU College of Pharmacy; Psychiatrist, Louis A. Cancellaro, M.D., and Sociologist, John O'Donnell, Ph.D., both of the Mental Health Clinical Research Center, Lexington, Ky.

How Members Rated The Journal In Opinion Survey

HOW DOES the *Ohio State Medical Journal* rate in the opinion of members of the Ohio State Medical Association? The answer to that question is vital, because *The Journal* is the official publication of the OSMA and, as indicated on its masthead, is "published by and for members of the Ohio State Medical Association."

In the OSMA Opinion Survey recently conducted, 60 questions and subquestions were presented for reply, and only one of these pertained specifically to *The Journal.*

In the overall survey, 9,975 questionnaire forms were mailed to OSMA members. The returns totaled 5,400 for a 55 percent response. Approximately 650 of the survey forms were not processed in the final tabulation because they were either received too late or were not sufficiently complete.

The question pertaining directly to *The Journal* was under item 7: "Rate the following as to their significance in keeping abreast of OSMA policies and activities — Very Important, Moderately Important, Not Important." Under b was listed *Ohio State Medical Journal.*

A total of 4,484 members responded to this question. Of that number, 1,286 (or 29 percent) rated *The Journal* "Very Important"; 2,488 (55 percent) rated it "Moderately Important"; and 707 (or 16 percent) noted "Not Important."

In other words, 84 percent of the members who responded to this question rated *The Journal* very important or moderately important, while the remainder felt that it was not important as a means of keeping up with OSMA policies and activities.

Under the question, "What comments do you have about the Ohio State Medical Association?" some 65 members (or 01.2 percent of total returns) volunteered opinions about *The Journal.* Comments varied from "excellent" to "atrocious," and in general were unfavorable.

Here are examples:

"Reference to Journal — quite interesting and educational."

"I enjoy both the monthly Journal and the newsletters . . ."

"The *Ohio State Medical Journal* is very poor from the standpoint of scientific and educational presentations. This should be improved."

"The *Ohio State Medical Journal* is worse than any publication I have ever seen. Its scientific papers are poor and only serve to allow publication of rejected papers."

"*The Journal* is not worth reading from professional standpoint, dominated by right wing, small town physicians who want only status quo."

"Also performing a very good job — the State Journal."

Unfortunately, as far as *The Journal* was concerned, the survey came after only the first issue under the "new format" had been distributed. But several comments related to the revised issue. For example:

"I have also liked the new type of cover of the *Ohio State Medical Journal.*"

"There has been great improvement in *The Journal.*"

Several constructive suggestions for improvement of *The Journal* were offered, such as the following:

"The new face of *The Journal* is an improvement. Now improve the contents."

"Believe *OSMJ* could be improved."

"Format of *The Journal* should change. More scientific material — less activities, political announcements, etc."

Editorial Comments

Association members who responded to the opinion survey can be assured that officers of the Association, members of the publications committee and staff members will study comments carefully and will be guided by the opinion survey in future plans for *The Journal.*

Obviously those who are responsible for *The Journal's* publication would like to see more members among those who feel *The Journal* is "Very Important" and will work in that direction. They also would like to improve *The Journal's* contents so that those who now feel it is "not important" will change their opinions.

It would seem from some of the comments that there is misunderstanding as to the purposes and scope of a State Medical Journal. The following observations would seem in order:

The Journal, with a circulation in the ten-thousand class, cannot compete with national medical journals in the 200-thousand circulation class.

With a readership separated into more than 30 branches of medicine, it cannot presume to compete with the specialty journals.

Published "by and for" OSMA members, *The*

Journal IS A FORUM primarily for Ohio physicians. That statement is made, not with apologies, but with pride.

Readers often refer to *The New England Journal of Medicine* as an ideal, either as a "regional journal" or as a state journal. It is true that *NEJM* is the official publication of the Massachusetts Medical Society, but it is a phenomenon in medical journalism. Its circulation is in the 115-thousand category and most of its readers are outside of Massachusetts and the New England States.

The Ohio State Medical Journal is a peer among State Medical Journals. Thirty-seven State Medical Associations and the Medical Society of the District of Columbia publish their individual journals; six states share a multi-state publication, and three states another; two states use bulletins to communicate with members, and one state shares a journal with other professional groups.

Members of the OSMA are invited to offer their comments on *The Journal* at any time.

Columbus Anatomist and Historian Dies

Linden F. Edwards, Ph. D., professor emeritus, and for many years professor of anatomy at Ohio State University College of Medicine, died in Columbus on April 8, at the age of 71.

A medical historian of high standing, Dr. Edwards contributed numerous articles to *The Ohio State Medical Journal.* He was long associated with the Ohio State Archaelogical and Historical Society, and the Ohio Academy of Medical History.

Other affiliations included membership in the American Association of Anatomy, the American Association for the Advancement of Science, the Ohio Academy of Science, and numerous other professional organizations. Survivors are his widow, a daughter, a brother, and grandchildren.

Dr. Robert M. Dumm, Kent, was one of four alumni to receive the Distinguished Service Award of Kent State University.

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High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities within 85 acres of landscaped and wooded grounds in the City of Asheville.

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Honored for Outstanding Service to OMI



At the Silver Anniversary celebration of Ohio Medical Indemnity, Charles H. Coghlan (right), OMI President receives a bronze plaque honoring him for his 25 years of outstanding service. Taking part in the presentation, from left, are Ralph L. Abernathy, OMI Secretary; Dr. Frank L. Shively, Jr., Chairman of the Board; and Senior Vice-President Michael J. Ketchum.

Ohio Blue Shield Celebrates Its Silver Anniversary

More than 175 persons attended the Silver Anniversary celebration of Ohio Medical Indemnity, Inc. on April 24 at the Sheraton-Columbus Motor Hotel.

Among persons present were members of The Council of the Ohio State Medical Association, including 1969-1970 President Robert N. Smith, of Toledo, and 1970-1971 President Richard L. Fulton, of Columbus; Past Presidents and members of the executive staff of OSMA; officers and board members of OMI and former officers and board members; representatives of Blue Cross plans, and many others.

There were several highlights of the evening. A resolution from The Council of the Ohio State Medical Association was read by its President, Dr. Smith, extending "sincere congratulations and commendation for the achievement of 25 years of steadfast adherence to the original premise of the founding fathers and for the exemplary conduct of this business with such capable and secure administration."

It was announced at the meeting that Charles H. Coghlan, for many years the Executive Vice-President of OMI, had been named President, and that Dr. Frank L. Shively, Jr., had been named Chairman of the Board.

Further honoring Mr. Coghlan, Dr. Shively unveiled a bronze plaque bearing the inscription, "The Board of Directors of Ohio Medical Indemnity, Inc., recognizes Charles H. Coghlan for his many years of service as chief executive officer since the founding of this Blue Shield Plan in 1945." The plaque will be placed in OMI's new

home office building, now under construction north of Columbus.

A plaque from the National Association of Blue Shield Plans in Chicago, honoring OMI, one of the charter members of the National Association, for its performance over the past 25 years, was presented by William E. Ryan, its Senior Vice-President of Marketing.

Dr. Shively presided as master of ceremonies for the anniversary celebration, spoke briefly of OMI's accomplishments and goals, and introduced distinguished persons.

Mr. Coghlan traced the company's growth from meager beginnings toward the end of World War II, to its present position as the sixth largest of the nation's 72 Blue Shield Plans.

Mr. Coghlan commented, "During its first ten years, OMI paid a total of $67 million in benefits to Ohioans. We now are paying more than $51 million annually, and are providing coverage to over 3 million people in the state. Total payments since 1945 have exceeded $428 million."

As Ohio's largest medical insurance company, Ohio Medical Indemnity serves almost a third of the state's population.

Ohio Medical Indemnity Goes into 26th Year; Reports Continued Expansion of Coverage

FOR Ohio Medical Indemnity, Inc., 1969 was a year in which foundations were laid for future progress. Highlights included activities necessary for continued growth, improved service to subscribers and physicians, and better communications with those whom it serves.

Having outgrown its present facilities on North High Street in Columbus, plans were laid and construction began on a new home office building north of Worthington, about 20 minutes drive from downtown Columbus. New and more sophisticated systems and equipment are in the process of implementation.

"But, the future success of OMI will depend on more than buildings and equipment—it must depend on people," said Dr. Frank L. Shively, Jr., Chairman of the Board. "We are continuing to build a strong management group, and their efforts are being supported by more and better trained employees."

"Assurance of continuing success at OMI requires one more essential factor," he continued. "Success for our concept of prepaid professional care is founded on the wholehearted support of the medical profession and the understanding and acceptance of the public."

Highlights of 1969

Here are excerpts of OMI progress in 1969 as outlined in the annual report.

More upgrading to better coverage was accomplished, highlighted by a 46 percent increase in UCR (usual, customary and reasonable) coverage . . . a 58 percent increase in Major Medical coverage.

A record 1,060,000 claims were incurred with payments totaling over $51,000,000, an increase of $9,000,000 over the previous year.

A reorganization of the Claims and Services Division along with new data processing equipment and systems resulted in significant improvements in claims service to subscribers. 85.5 percent of the subscriber's claims were paid within ten working days — 98.9 percent of the telephone inquiries were responded to within 24 hours.

New departments and the need for expanded staff added 48 more employees. The Corporate Planning Division and the Budget and Costs Department were organized and became fully operative. Physicians Relations and Marketing staff was expanded with the employment of three area representatives working out of Cincinnati, Toledo and Youngstown.

To help satisfy the need for new products in 1969, a new $450 contract for direct pay subscribers was introduced in the southwest Ohio area, and, by year's end, over 89,000 members were enrolled. Introduction of this contract in the other areas of Ohio is part of the 1970 program. Work also started on the design of coverage for dental services, and is continuing in 1970.

A public service campaign dealing with drug abuse was highly successful. A three part television documentary, "The Distant Drummer," was shown in five major cities of Ohio, and 90,000 copies of a 48-page booklet, "Drug Abuse: The Chemical Cop-Out," were distributed to individuals and organizations.

Equal employment opportunity goals were met for the year, with continued work and improvement taking place.

Ground was broken for the new home office building in August of 1969. The $3.5 million

complex will be located in Worthington, just north of Columbus. The 100,000 sq. foot building will contain general offices, a data processing center and an employee cafeteria. This will allow OMI to bring together its employees, who are now in four separate buildings, and will provide a more efficient operation with room for future expansion.

Enrollment Expansion

Here are additional notes on enrollment for 1969.

In 1969, OMI directed its efforts to upgrading subscribers to a higher level of coverage, with strong emphasis on the Usual, Customary and Reasonable Contract.

It continued to develop new business, as well, gaining 28,613 contracts over 1968 — a total of 1,312,964 contracts, covering 3,092,698 Ohioans.

The usual, customary and reasonable program continues to be the trend for more and more people . . . OMI gained 80,463 contracts, up 46.4 percent . . . a total of 253,830 contracts or 600,055 members.

During the latter part of the year, the UCR contract was also offered as high option under the Federal Employees Program for the first time. All indications point to a successful campaign in Ohio.

As a result of upgrading efforts, the *Standard* Group Contract was reduced by 25,660 (59,935 members), down 22.3 percent . . . while the *Preferred* decreased by 35,371 contracts (92,360 members), down 10.3 percent.

The *Major* Group Contract changed slightly, down 3,986 contracts (9,908 members), or 2.4 percent — while the *Select* increased by 5,802 contracts (13,341 members) up 23.9 percent.

Major Medical coverage continued to rise beyond expectations — up 46,356 contracts, or 58.6 percent.

OMI expanded its upgrading to include the direct-pay area, as well, initiating in the Fall a new $450 indemnity contract called the "450" — Already 39,478 contracts (89,005 members) have been enrolled in Southwest Ohio.

As group conversion and nongroup members moved to a higher level coverage, the *Standard* contract decreased by over 20,000 contracts — while the *Preferred* decreased by over 27,000 contracts.

The total enrollment picture indicates a definite healthy trend to better coverage.

Board Members Elected

At its annual meeting Ohio Medical Indemnity, Inc., elected or reelected the following members to the Board of Directors: Ralph L. Abernathy; Dwight L. Becker, M.D.; William T. Blair; Guerney H. Cole, Jr.; William R. Culbertson, Jr., M.D.; Donald W. De Wald, M.D.; Clair E. Fultz; Paul A. Jones, M.D.; Robert E. Howard, M.D.; William B. McKelvey; Robert A. McLemore, M.D.; John R. Meek, M.D.; Usher B. Redmann; Theodore T. Reed, Jr.; James G. Roberts, M.D.; William J. Schrimpf, M.D.; Frank L. Shively, Jr., M.D.; M. M. Thompson, Jr., M.D.; Gordon M. Todd, MD.; William A. White, Jr., M.D.

Ohio Physician Honored by Michigan Alumni

Dr. Charles L. Hudson, Cleveland, received the University of Michigan Club's Outstanding Alumnus Award at a dinner in the Cleveland Athletic Club on April 28. The meeting marked the 153rd anniversary of the founding of the University of Michigan, located at Ann Arbor.

Dr. Hudson is a Past President both of the Ohio State Medical Association, and of the American Medical Association. He is associate professor of internal medicine at the Cleveland Clinic Foundation, and has served as a professor of health at Case Western Reserve University and as director of the University Health Service. He has been affiliated with University, Veterans Administration and Cleveland Clinic Hospitals. Dr. Hudson has received an honorary LL.D. degree from Alma College and the Distinguished Service Award of the Cuyahoga County Medical Society, of which he was also president.

Presentation of the award to Dr. Hudson highlighted a program that featured an address by Wilbur J. Cohen, dean of Michigan's School of Education and former Secretary of Health, Education and Welfare. He spoke on "Education for the Seventies: A Program for the Era of Radical Change."

Dean Cohen was introduced by Federal Judge Anthony J. Celebrezze, also a former HEW secretary and five-term mayor of Cleveland.

The Daily Jeffersonian, of Cambridge, recently published a feature article on Dr. James A. Toland, regarding his activity in conducting classes in oil painting at the Cambridge Area YMCA. A former private practitioner in Cambridge, Dr. Toland is now on the professional staff at Cambridge State Hospital.

Officers and AMA Delegates Elected at the 1970 Annual Meeting

DR. RICHARD L. FULTON, was installed as President of the Ohio State Medical Association at the final session of the House of Delegates on May 14, during the 1970 OSMA Annual Meeting in Columbus. Dr. Fulton is a practicing physician in Columbus, specializing in internal medicine. He is a past president of the Academy of Medicine of Columbus, a former delegate of the Academy to the OSMA House of Delegates, and served as Councilor of the Tenth District before being named President-Elect last year.

Dr. Fulton succeeds Dr. Robert N. Smith, of Toledo, who will serve an additional year on The Council as Immediate Past President.

Dr. P. John Robechek, of Cleveland, was named President-Elect, and will succeed to the Presidency at the 1971 OSMA Annual Meeting, to be held again in Columbus. Dr. Robechek is a practicing surgeon in Cleveland, a Past President of the Academy of Medicine of Cleveland, has served six years as Councilor of the Fifth District, and is a Delegate to the American Medical Association.

The House of Delegates elected one new Councilor, reelected five Councilors, and reelected the Treasurer.

Dr. David Fishman, of Cleveland, was elected Councilor of the Fifth District to succeed Dr. Robechek. Dr. Fishman practices internal medicine emphasis on gastroenterology. In addition to his private practice, he is president of the Hough-Norwood Health Services program, is professional relations director of the Blue Cross Plan of Northeast Ohio, and is on the internal medicine faculty at Case Western Reserve University School of Medicine. He is a Past President of the Academy of Medicine of Cleveland, and has served as delegate to the OSMA House of Delegates.

Reelected as Councilors are Dr. Paul N. Ivins, Hamilton, First District; Dr. Dwight L. Becker, Lima, Third District; Dr. Sanford Press, Steubenville, Seventh District; Dr. Oscar W. Clarke, Gallipolis, Ninth District; and Dr. William R. Schultz, Wooster, Eleventh District.

Dr. James L. Henry, Grove City, was reelected Treasurer of the Association for an additional three-year term.

Councilors in the midst of two-year terms are Dr. George J. Schroer, Ft. Loramie, Second District; Dr. George N. Bates, Toledo, Fourth District; Dr. Maurice F. Lieber, Canton, Sixth District; Dr. William M. Wells, Newark, Eighth District; and James C. McLarnan, Mount Vernon, Tenth District.

Four Delegates to the American Medical Association were named for two-year terms beginning January 1, 1971: Dr. Richard L. Meiling, Columbus; Dr. Lawrence C. Meredith, Elyria; Dr. Robert N. Smith, Toledo; and Dr. Robert E. Tschantz, Canton (reelected).

Carry-over Delegates are Drs. John H. Budd, Cleveland; Philip B. Hardymon, Columbus; Harry K. Hines, Cincinnati; Frederick P. Osgood, Toledo; and P. John Robechek, Cleveland.

Four Alternate Delegates also were elected for two-year terms beginning January 1, 1971: Dr. Dwight L. Becker, Lima; Dr. Oscar W. Clarke, Gallipolis (reelected); Dr. Henry A. Crawford, Cleveland (reelected); and Dr. H. William Porterfield, Columbus.

The election of Dr. Smith and Dr. Meredith as Delegates left two one-year unexpired terms among the Alternate Delegates. Dr. George N. Bates, Toledo, and Dr. Jerry L. Hammond, West Milton, were elected Alternate Delegates for one-year of the unexpired terms beginning January 1, 1971.

Carry-over Alternate Delegates are Drs. William J. Lewis, Jr., Dayton; Frank H. Mayfield, Cincinnati, and Jack Schreiber, Canfield.

Because of the time element involved, only this brief summary of election results could be included in this issue of *The Journal*. Watch for the July number and complete reports of the 1970 Annual Meeting, including official minutes of the House of Delegates.



Investment Prognosis

By Frank Van Holte, Columbus

A SMOG OF GLOOM has settled over the market and it is difficult to be optimistic. The Dow Jones Averages have dropped to a 6½-year low, inflation has not been stopped, the labor market is unsettled, corporate profits are down and other weaknesses appear in the economy. Market analysts are pulling in their horns and are beginning to doubt their prognosticative capacities, and the current volume of transactions on the large exchanges vividly demonstrates the restraints in committing new funds to the market.

But I also see some breaks in the smog. The first-quarter earnings reports issued to date indicate that corporate profits are about 10 percent lower than the first-quarter profits of last year. A spot check of these reports denotes, however, that 54 percent of the corporations have increased earnings compared to last year; 42 percent show less earnings, and 4 percent are even. So the decreases are not general, which emphasizes the importance of selection.

Capital expenditures remain strong even in this period of uncertainty and consumer buying power remains immense, and this will be strengthened by wage hikes this year, including federal employees. There has been a severe cutback in the sale of automobiles but over six million cars are junked or scrapped each year, so the public cannot hold off buying indefinitely. And the big spender, Uncle Sam, shows no sign of a letup. So, this market continues to offer, in my opinion, a time for selective buying.

I believe the building industry and construction field offers good long-term growth possibilities. A good way to participate in this growth is through the purchase of shares in one of the real estate or mortgage investment trusts. Tight money conditions have made it extremely difficult for construction companies to finance their building projects. These trusts provide funds for the builders on a short term basis, at substantial interest rates. Investments are also made in first mortgages insured by the V.A. or the FHA, and also in conventional first mortgage loans on residential and income producing commercial and industrial properties. This is a new kind of business and seems to fill a real need in today's economy.

I mentioned in a previous column the investment opportunities offered by companies involved in pollution control. It has now become a national issue with some mention appearing in the newspapers each day. It is estimated that expenditures in this field will soon reach $10 billion a year. About 7,000 communities with a total population of over 50 million, have serious air pollution problems. When you consider that each day, over 400,000 tons of pollutants are expelled into the air, mostly from automobiles, you begin to understand the scope of the problem. From an investment point of view, though, this problem becomes an opportunity.

Do you remember the story of the red gasoline fuel truck that always managed to arrive at the next airport before your airplane? I recently read a bond prospectus on the Chicago-O'Hare International Airport, which revealed some facts about this airport which are astounding.

The fuel trucks are gone from O'Hare. A tank farm area has been established in the northwest corner of the airport beyond the hangar area. These tanks receive fuel by pipe line, railroad tank car, and truck. The tank farm is connected to satellite storage facilities located around the terminal apron, and to the hydrants at the aircraft parking positions, by a system of underground pipelines. Above-ground tanks are available for storing 5,000,000 gallons of fuel. Underground tanks in the satellite areas store 2,000,000 gallons of fuel. This fueling system now delivers 2¼ million gallons of fuel per day to the aircraft. The system will be expanded in the future to deliver the estimated requirements of five million gallons per day in 1975.

The system expects to serve 30 million enplaned passengers anticipated in 1975, up from 15 million in 1968. This huge airport covers 7,000 acres and will jump from six runways to 11 runways by 1975. A far cry from the days of the red fuel truck meeting the few flights per day. This airport must be one of the wonders of the modern world.

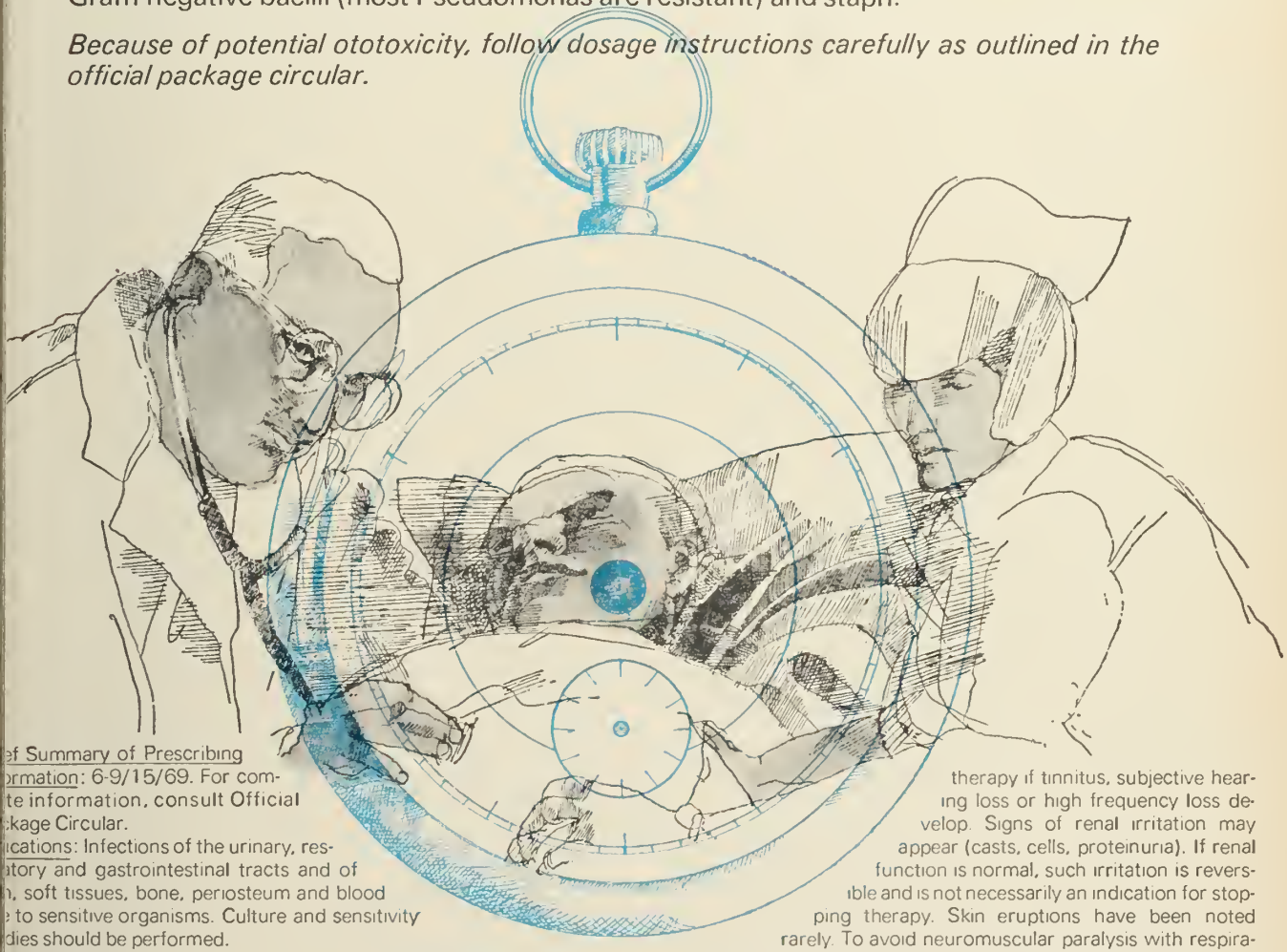
This monthly feature is written for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

A valuable hospital antibiotic —when there is no time

in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

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or auditory damage by kanamycin or other agents may be a contrain-
ation if effective alternative therapy is available.
rnings: Since the drug is excreted almost entirely by glomerular
ation, renal malfunction can cause abnormally high serum levels of
amycin which may prove ototoxic. Assess renal function periodi-
y, both before and during therapy. Renal dysfunction or pre-renal
temia sharply increase the risk of ototoxicity and permanent deaf-
s. In such cases decrease the size and frequency of doses. Discontinue
amycin and check hearing if azotemia increases. In older patients
l patients receiving a total dose in excess of 15 Grams, watch care-
y for signs of ototoxicity.
cautions: If mycotic or bacterial superinfection occurs, discontinue
amycin and initiate appropriate therapy. Cumulative ototoxic effects
y be produced by concurrent or consecutive use of other ototoxic
gs. High doses may cause irritation at injection sites. The drug *should*
be physically mixed with other antimicrobials.
verse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete.

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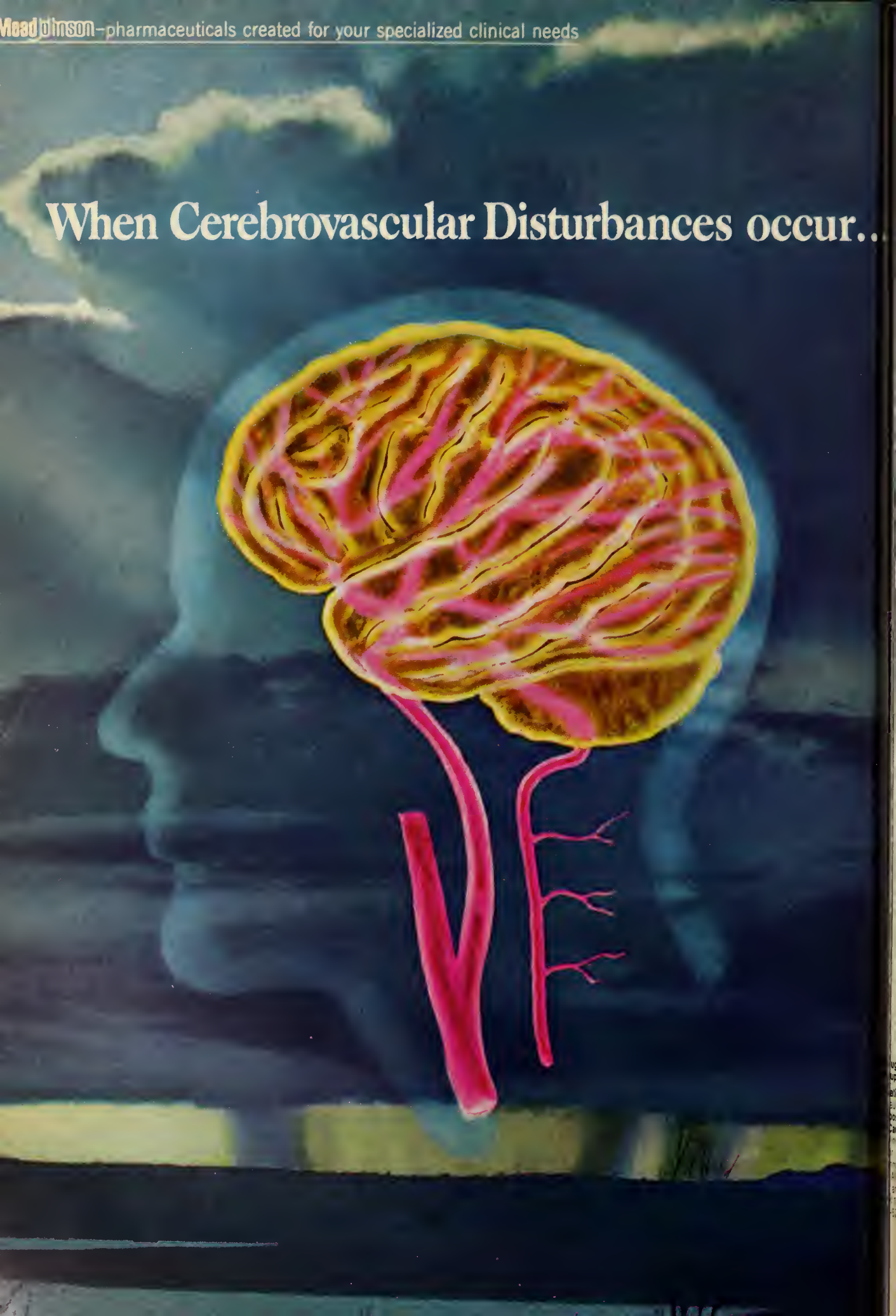
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tions: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), ud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **osition:** VASODILAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications autions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial ng. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not mended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas, Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology 87 (Feb.) 1964.

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Obituaries

OSMA Past President Dies in Florida

George Albert Woodhouse, M.D., former Ohio practitioner, Past President of the Ohio State Medical Association, and former OSMA Delegate to the American Medical Association, died in his Miami Shores, Florida, home on April 21 at the age of 70.

Dr. Woodhouse was born at Jacksonville, Athens County, and in 1924 received his medical degree from the University of Cincinnati College of Medicine. A year later he opened an office at Pleasant Hill, Miami County, and continued as a practitioner there until the early 60's. For 25 years he was secretary of the Miami County Medical Society, and for many years was delegate of that Society to the OSMA House of Delegates.



Dr. Woodhouse

He served the Second Councilor District both as president and as secretary. He worked on one or more State Association committees continuously for many years beginning in 1938. In that year he was named a member of the Judicial and Professional Relations Committee. In 1940 he was named on the Medical Service Plans Committee; also he served on the Public Relations and Economics Committee for several years, and on the Subcommittee on Legislation, being its chairman in 1949.

Dr. Woodhouse was first named a Delegate to the American Medical Association in 1942 and served in that capacity for many years. He was for many years on the AMA Judicial Council, the body which interprets the AMA Principles of Medical Ethics.

He was first elected to The Council of OSMA in 1953 as Councilor of the Second District. In 1957 he was named President-Elect and subsequently served in 1958 and 1959 as President. He was appointed by the governor to the Hospital Advisory Council to the Ohio Department of Health and also named to the Governor's Committee on Hospital Care.

Dr. Woodhouse moved to Florida in the early 1960's and for several years was resident physician for the Miami Military Academy. He was a veteran of World War I, and was affiliated with several Masonic bodies. Survivors include his widow, a daughter, two sons, and a brother. One of his sons is Dr. George A. Woodhouse, Jr., of Cincinnati.

William Henry Benham, Jr., M.D., Columbus; Ohio State University College of Medicine, 1943; aged 54; died April 1; member of the Ohio State Medical Association, the American Medical Association, the American Society of Clinical Pathologists; Fellow of the College of American Pathologists; diplomate of the American Board of Pathology; from 1952 to 1957 private practitioner in Toledo; from 1957 to 1964 associate director of laboratories at Toledo Hospital; from 1964 pathologist and associate director of Grant Hospital in Columbus; veteran of World War II; survived by his widow, a daughter, a son, two sisters, and a brother.

John A. Bradley, M.D., Sunland, Calif.; Jefferson Medical College of Philadelphia, 1906; aged 92; died February 27; former member of the Ohio State Medical Association; practitioner in Steubenville from 1912 to 1946; later moved to California; survived by two daughters, and three sons.

Walter I. Greenson, M.D., Toledo; Chicago Medical School, 1943; aged 53; died April 1; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Dermatology; practitioner in Toledo for 22 years, specializing in dermatology; veteran of World War II; member of the Toledo Orchestra Association and member of Collingwood Temple; survived by his widow, a son, a daughter, his mother, a brother, and two sisters.

Howard Thomas Karsner, M.D., Washington, D. C.; University of Pennsylvania School of Medicine, 1903; aged 91; died April 8; member of the Ohio State Medical Association, the American Medical Association; Fellow of the American College of Physicians; member of the American Association of Pathologists and Bacteriologists, and numerous other professional organizations; diplomate of the American Board of Pathology; from 1929 until 1949, professor of pathology and chairman of Department of Pathology at Western Reserve University, and later director emeritus of the Institute of Pathology there; until his retirement in 1959, adviser on medical research to the

surgeon general of the Navy; during World War II, consultant to the air surgeon; survived by his widow.

Carl J. Katz, M.D., Covington, Ky., and Cincinnati; Western Reserve University School of Medicine, 1929; aged 64; died December 30; practitioner for many years in the Covington, Ky., area; recently resident of Cincinnati; survived by his widow, two daughters, his father, a sister, and a brother.

Clement Earl Kelley, M.D., Lima; Indiana University School of Medicine, 1944; aged 49; died March 24; member of the Ohio State Medical Association, the American Medical Association, and the Radiological Society of North America; Fellow of the American College of Radiology; diplomate of the American Board of Radiology; chief radiologist at Lima State Hospital; also associated with other hospitals in the area; veteran of World War II; member of the Rotary Club, Elks Lodge, several Masonic bodies, and the Calvary Bible Church; survived by widow, two sons, his mother, and a sister.

Carl Owen Kent, M.D., Cleveland; Meharry Medical College, 1929; aged 72; died April 21; Member of the Ohio State Medical Association, and former member of the American Medical Association; member of the National Medical Association; physician and surgeon of long standing in Cleveland; member of the NAACP, Conference of Christians and Jews, Urban League, the YMCA, the Baptist Church, and several fraternal groups; survived by his widow, a daughter, his mother, five sisters, and a brother.

Chester Clyde Kirk, M.D., Columbus; Ohio Medical University, Columbus, 1902; aged 91; died April 12; member of the Ohio State Medical Association, the American Medical Association, and the American Psychiatric Association; psychiatrist and pioneer in therapeutic treatment of patients in mental hospitals; 1906 to 1917, staff physician at Toledo State Hospital; 1917 to 1927, superintendent at Arkansas State Hospital; 1927 to 1954, superintendent at Orient (Ohio) State Institute; member of the Rotary Club, Congregational Church, and other organizations; survived by two sons, Dr. Robert C. Kirk and Dr. Gilman D. Kirk, both of Columbus; a daughter, and a brother.

Earl Desbury McCallister, M.D., Columbus; University of Iowa College of Medicine, 1925; aged 72; died April 2; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the American Geriatrics Society; general practitioner of long standing, first in Chillicothe and later in Columbus; one of the founders of the Ohio Academy of General Practice and its executive secretary for a number of years; also former secretary-treasurer of the Central Ohio Academy of General Practice; member of the Masonic Lodge and the Presbyterian Church; survived by his widow, a stepson, a stepdaughter, and a brother.

Francis Wallace McNamara, M.D., Youngstown; Jefferson Medical College of Philadelphia, 1911; aged 82; died March 27; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons and the International College of Surgeons; diplomate of the American Board of Surgery; past president of the Mahoning County Medical Society; practitioner in the Youngstown area for more than 50 years; industrial physician and surgeon for several local firms; veteran of World War I; member of a number of local organizations; survived by a sister.

Russel Garrett Means, M.D., Columbus; Ohio State University College of Medicine, 1919; aged 74; died April 25; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; diplomate of the American Board of Otolaryngology; former professor and later professor emeritus at OSU College of Medicine; past president of the Academy of Medicine of Columbus; member of numerous fraternal, community, and civic organizations, among them the Chamber of Commerce, Metropolitan Health Center, Columbus Hearing Society; served on Committees of the OSMA; member of the Masonic Lodge, the Grange, Sons of the American Revolution; cited for his part in the original drive which resulted in the present OSU Medical Center; survived by his widow, two daughters, a son, and a sister.

James Martin Muckley, M.D., Canton; Ohio State University College of Medicine, 1941; aged 54; died March 31; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Orthopaedic Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery; practitioner in Canton since 1948, specializing in orthopaedic surgery; veteran of World War II; member of the Lutheran Church and the Fraternal Order of Police of Ohio; survived by his widow, two daughters, his parents, a sister, and a brother.

Zol Filip Muskovitch, M.D., Evansville, Ind.; University of Saskatchewan College of Medicine, 1958; aged 37; died December 22; member of the Ohio State Medical Association, the American Medical Association, and the American Geriatrics

Society; formerly located in the Cincinnati area and recently associated with the Mead Johnson Company with headquarters in Evansville.

Ora Walter Rapp, M.D., Mt. Vernon; Ohio State University College of Medicine, 1928; aged 76; died April 6; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; general practitioner in Mt. Vernon for about 30 years; formerly practiced in Fredericktown; veteran of World War I, member of the Presbyterian Church, Lions Club, Exchange Club, and the Masonic Lodge; survived by his widow, two daughters, a half-sister and a half-brother.

Herbert Ulysses Seabrook, M.D., Dayton; Meharry Medical College, 1953; aged 45; died April 15; member of the Ohio State Medical Association and former member of the American Medical Association; practitioner in Dayton for 14 years, specializing in pediatrics; veteran of World War II; survived by his widow, and his mother.

Adam Edward Sitkoski, M.D., Cleveland; Ohio State University College of Medicine, 1915; aged 78; died March 29; former member of the Ohio State Medical Association; general practitioner and obstetrician in Cleveland for more than 50 years; member of the Medical and Dental Arts Club of Cleveland, the National Physicians and Dentists Association, the Catholic Church, and the Catholic Physicians Guild; survived by his widow, two daughters, a son, and two sisters. Dr. Angela Adams—Jablonski is a daughter.

Carl Farnan Ulrich, M.D., Cleveland; Western Reserve University School of Medicine, 1918; aged 78; died July 3; member of the Ohio State Medical Association and the American Psychoanalytic Association; practitioner of many years standing in the Cleveland area where he specialized in psychiatry.

William Francis Vinnedge, M.D., Hamilton; University of Cincinnati College of Medicine, 1933; aged 64; died April 18; member of the Ohio State Medical Association and the American Medical Association; resident of long standing in Hamilton and practitioner there since 1934; engaged in general practice until a few years ago when he began specializing in anesthesiology; veteran of World War II; member of the Presbyterian Church; survived by his widow; a son, a daughter, and his mother.



Take Note of Issues Facing Medicine

PARTICIPATION WAS THE KEYNOTE of the OSMA Key Man Conference for County Medical Society leaders held in Columbus March 8. County Society officers and key committee chairmen met in small groups made up of representatives of the smallest to the largest county societies for two hours of "brainstorming" on more than 20 issues facing medicine today.

Discussion leaders then reported to a general session the conclusions and recommendations of their groups. Following are the conclusions of those groups whose discussion leaders prepared written reports:

By Oscar W. Clarke, M.D., Gallipolis
and
James L. Henry, M.D., Grove City

1. Through discussion and also from direct observation of a recent panel held by state labor groups regarding the future of their medical care, it appears at the present time that there is some doubt concerning the immediate development of National Health Insurance due to the cost of the project. It appears that there will be a strong effort throughout the state for the development of "closed panel" prepaid medical care schemes developed primarily by labor groups. In order to offer the patient freedom to select the doctor of his choice we feel that every effort should be made to provide this method of choice. It was, therefore, the opinion of this group to recommend to the Council of the Ohio State Medical Association that Blue Shield be approached concerning the possibility of developing a comprehensive **outpatient care policy** which could be competitive with the prepaid closed panel schemes.

2. OMPAC was discussed. There appeared to be no great dissatisfaction with the operation of OMPAC; however, those physicians who have made contributions feel that they should get some type of regular news letter in regard to the activities of OMPAC.

3. The group discussed the general situation of malpractice insurance, and all of the phases involving this complex question and asked that a request be directed to our AMA delegation that they urge AMA to explore every possibility of national or state legislation to provide some type of shelter from this rapidly expanding hazard to the freedom of practice and the welfare of the patient and the physician.

4. Utilization review was discussed in detail and in depth. We had resource information given us concerning the screening of utilization reports by the third parties. It seems as if the third parties are now implementing to the very finest degree the Federal Directive 371 and not to be surprised if the hospital, several months after a patient is discharged, finds that that hospital stay was not allowed. The physician and the Utilization Committee of all hospitals should become fairly familiar with Federal Directive 371 regarding the indication for hospitalization and also the indication for skilled nursing care.

It was felt that there will eventually develop a length of stay in the hospital comparable with a disease category and that guidelines in this direction will probably be used by the third party reviewers.

The group directed that the Ohio State Medical Association Council form a committee or direct one of its existing committees to prepare a uniform guideline booklet for the use of the utilization Committees in our state. Such a book would serve to clarify the various differences being employed in different hospitals within the state and also would be of considerable help in avoiding third party rejection.

5. It was the feeling of the members of both discussion groups that community hospitals should make provisions for third and fourth year medical students as preceptors or as clerks in every manner possible in keeping with the students proficiency to serve the patient. It was felt that the academic atmosphere is not furnishing a vital and necessary element in the medical student's background for clinical practice and that this could be a very decisive factor in encouraging more students to enter the clinical practice of medicine versus research and academic medicine.

6. Physician's assistants — This was discussed in detail and as everyone is aware phyician assistants are now being employed in all different guises and names. Many of the returning medical corpsmen in several communities are now availing themselves of community college courses of

10 to 16 weeks duration and are securing a certificate of licensed practical nurse. This certificate definitely gives them a status in the "pecking-order" within the hospital structure. It was the feeling of all of the group that adequately trained, properly directed physician assistants could be utilized in as many categories as desired by the physician providing they have the proper direction, supervision, and preparation for their duties. Doctor Robert Smith's project for the placing of a number of returning medical corpsmen in the outpatient offices of physicians in the Toledo area as a study project was discussed. It was felt that the results of this study will be most helpful and that this project not only is encouraged, but it was felt that similar projects would be most helpful throughout different locations in the state.

7. It was presented to the group by a representative of third party plans that there appears to be coming from Washington now more and more inquiries, questions, and suggestions regarding the quality of medicine being practiced and the competence of the physician who is rendering this service. This is just beginning. It is felt that we as physicians will definitely have to provide some type of quality control mechanism very shortly and that this should be as effective as possible, but also should be developed with considerable thought in order to prevent intrusion, interference, and obstruction to the doctors freedom to practice and not to create a "snowballing" of unnecessary tests to indicate that the physician is competent.

8. Drug abuse appeared to be a question in the mind of most of our discussants, and it was felt that each man should avail himself of all information possible regarding the many facets of this problem. It was also felt that the State Medical Association should keep its membership abreast of any new developments in this field, and it was strongly recommended that the Ohio State Health Department establish a division of Drug Abuse Control. It was brought out that at the present time no such division existed in the State Health Department, however, it was readily acknowledged that the State Attorney General's Office was doing an excellent job in this field and should be encouraged. This problem is so entwined with legal aspects that it cannot be considered wholly as a medical matter nor on the other hand can it be considered wholly as a legal matter. This is a problem which will require close co-operation with all concerned.

9. The last item discussed due to available time was that of medical ethics. It was recognized that in the smaller medical societies that at times it is extremely difficult for the Medical Ethics Committee to rule or act against one of its members due to the previous close personal association of the committee with the member in question. It is not possible for a Medical Ethics Committee to disqualify itself in considering the problem of one of the society members. However, if the relationship is extremely close and the Medical Ethics Committee feels that they are unable to render a fair and impartial decision then it should be mandatory that the Medical Ethics Committee submit its problem to a sister county medical society that has a similar background and ask that society's Medical Ethics Committee to consider the case in an unidentified manner. When a decision has been reached this decision should be considered by the local county medical society Medical Ethics Committee, and the opinion either accepted in whole or used as judgment or rejected as the case may be. It was felt by the group that there was no possible acceptable excuse for a Medical Ethics Committee not acting on a case within its jurisdiction.

By Carl G. Madsen, Jr., M.D., Painesville

Should county societies survive? Even now in some respects they don't "exist." For instance, for the purpose of the Hill-Burton Act, they "exist" only as a percentage in a regional allocation. They hardly exist for the 239 and 749 regions except to provide an outline. However, they should exist when important for representation of local medical priorities, as in non-urban areas. Urban intra-county priorities may warrant subdivision for appropriate representation. Following the medical auxiliary's model, an Ohio State Medical Association "membership-at-large" might relieve some inequities. It would be ironic if the medical auxiliary, innocent of acquisitive desire for "third party" funds, should furnish the county society model its survival. Increased organization of the councilor's job, including additional staff help and technical aid such as closed circuit telephone conferences, would improve the councilor's function and district priority definition.

The doctor-patient relationship may not survive health insurance pressure for payment "in full" and attendant regulatory measures.

"In full" is a lie. Since it is not an indemnity program, controls on expenditure must be imposed in another way than by dollar limitations. Hospitals are warned to expect limitations in imbursement based upon restricted stay for varying categories of illness. Physicians' medical prescriptions for hospitalization will not be honored without challenge by a fiscal agency. What it is, then, that "third parties" sell their clients "in full," if not



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freedom from financial limitations? They sell words and require the medical profession make those words "come true." They switch controls from dollars to physicians' freedom to prescribe, an evasive sales maneuver in which the switch goes unmentioned, violating clients' right to 'truth in packaging.' "In full," then, is a lie and many in the medical profession, perceiving the lie, oppose it. Much utilization review is instigated to bolster the credibility of "in full." Well intentioned physicians admonish skeptical colleagues to accept "in full" as valid.

The divided profession is ripe for exploitation. Must our clinical edifice be subjected to rape before private practitioners can enjoy the plaudits accorded conservationists opposing the rape of natural resources? Let enterprising men in all professions restrain themselves from seeking clinical solutions to financial problems.

Physicians, deal with your patients!

By Marvin McClellan, M.D., Cincinnati

At the Key Man Conference, Sunday, March 22, 1970, groups 10 and 12 combined with eight of us discussing four problems in medical care. The first problem discussed concerned ancillary help in the delivery of health care. Everyone agreed that people in this class of medical help would need a certain amount of specific training to be useful and that this might well vary depending on where the help was to be used. In other words a corpsman could not come out of the military service and immediately be useful in civilian medicine.

It was decided that using this help would be easier for a young physician than an older physician because of training and established habits, and attitudes in the delivery of health care of the physician. All agreed that a mutual understanding of the physician's manner of doing things would be important so that contrary advice would not be given by the ancillary help and also so the physician could feel comfortable with and rely on his help. Licensing was thought unnecessary. There was some concern with patient acceptance since people really want to see the doctor.

The problem of locating physicians in rural or ghetto areas is probably dependent of the motivation of the physician, the opinion of his wife and whether he can be paid at a level consistant with his projected needs. One member suggested a 2 year army service period in the ghetto in exchange for no duty in Vietnam or elsewhere. Another member thought that year round head start should be expanded to get the children educated out of the ghetto and thereby eliminating the ghetto, would be a more lasting solution.

A three to six week preceptorship of senior medical students with a practicing physician was discussed and the majority agreed it would be stimulating to them and the medical students. It was recommended as a senior elective.

Medicare and Medicaid Insurance was discussed with Mr. Hughes of Nationwide. He confirmed that the insurance company responsible for this payment may decide on the number of days of care they will pay for these patients regardless of the statements of the physician or the utilization committee. He advised each hospital to establish an optimum length of stay for each illness. Then, when the length of stay for a patient deviates from this, a full explanation to the insurance company may result in coverage despite that deviation. At least the patient will have a better chance for full coverage this way. Mr. Hughes doubted that city-wide, state-wide or national norms for length of stay for each illness would be forthcoming but this discussion group foresaw such a probability.

By H. William Porterfield, Jr., M.D., Columbus

Following is a summary of the group's report from the Key Man Conference meeting of March 22!

Question: Is the county medical society dead, is the county medical society necessary?

It was the conclusion of this discussion group that the county society is very necesary as an integral part of the organized medical structure. It was agreed that the smaller rural counties could combine with other small rural counties for some functions, particularly in such areas as regional planning, etc. It was noted that any union of small counties with larger counties would be contraindicated and not in the best interest of the smaller county organizations. However there are some problems remaining with the county itself that need the attention of the local county society to provide proper resolution of these problems.

It certainly was the conclusion of this group that the local county society is both alive and necessary.

Question: The problem relating to salaried-hospital based physicians.

This question was relating to those physicians providing health services, not teaching services, wherein the hospital charges the patient the services and the physician is on salary. The group unamimously opposed this type of practice and was quite adamant in its positions that this placed the hospital in the practice of medicine which is a violation of the Ohio code. It was

the belief of the group that organized medicine must take a strong stand on this type of medical practice and make every effort possible to correct this situation. It was recognized by the group that in many areas in many situations physicians are dominated by hospitals and this was felt to be most unacceptable.

Question: Physician's assistants.

This is in relation to the area of trained physician's "helpers." It was recognized by the group a distinct need for a solution to the health manpower shortage. Assistants to the physician provide an answer to this problem in some degree if the responsibility for health care remains still in the hands of the physician. It was felt strongly by the discussion group that the assistant or physician's helper must be the second in line in relation to the patient and not be placed between the patient and the physician at the initial contract. It was recognized that there are instances wherein the assistant can carry out interval follow-up care to the patient and augment the physician's capability of delivering health services.

Question: Participation by doctors of osteopathy in hospitals, in county medical societies.

It was the conclusion of this group that there was a definite need to bring in the D.O. physicians to the hospitals and county societies — if qualified. It was strongly felt that there be no grandfather clause applied but that the osteopath be judged on the basis of his abilities. It was felt that there was a distinct need to provide continuing education and this can best be done by interdigitating the osteopath into the hospital environment and offering the medical education services to him. In turn it was felt that it was not reasonable to bring them into the hospital without also bringing them into the county medical society and to give them this status as members of the society.

In summary, it was the opinion of the group that full participation by the osteopath was the ultimate answer to this D.O. — M.D. relationship.

It was the opinion of the discussion leader that there was a decided attitude of progressive thinking within the group and also within other discussion reports which would be a most healthy sign to the solution of the medical problems facing medicine and particularly the organized medical structure.

By Marshall R. Werner, M.D., Akron

It was my pleasure for my group to join Dr. Porterfield's Group 13 and the formal report of the group was very ably presented by Dr. Porterfield.

The first item discussed, related to the viability of the county societies in our present hospital-oriented environment. It was the unanimous opinion of the representatives of both large and small county societies that the county society is a vital and necessary unit in carrying on our general community effort and in providing guidance and support to the hospital staff members who would otherwise be impotent because of their inability to stand singly against the American Hospital Association and other pressure groups. This was evidenced by the fact that the members immediately turned to the society for help in case of trouble.

Next, the relationship of doctors of osteopathy and their place in the societies and hospital staff was considered. Again, there was unanimous agreement that qualified doctors of osteopathy should be given a place on the hospital staff in order to help them in their continuing medical education and thus better serve the public need for quality medical care and at the same time help alleviate some of the shortage of house staff. This should very definitely be coupled with their admission to full membership in the local societies and state associations in order to have a better working agreement between the groups which again was felt to be in the public interest.

Various types of contract practice were discussed with the concensus of opinion reflecting approval of the principle of physician-controlled groups, but vigorously opposing any lay corporation or entity selling the services of physicians. The action of the Ohio State Medical Association toward clarifying this issue was approved since it was generally agreed that any of our Model Cities programs, etc. could readily be handled within the framework of the existing legal structure. This concept also did not appear to preclude the use of full-time medical educators in hospital staff positions as heads of departments, but did definitely delineate their contractural relationship with the hospital staff and patient. Vigorous opporition to the concept of corporate practice by lay groups was expressed and it was felt that the failure of this concept would mean the end of private practice as we know it.

All agreed that there was a definite risk in the indiscriminate use and training of medical assistants but at the same time all felt that they were at present utilizing some form of help by nurses or others in their practice and would lose considerable efficiency if this were not done.

By Roland L. Kennedy, M.D., Toledo

Utilization is a popular subject being considered by these panels. The feeling was expressed

that emphasis on efficient utilization will threaten the physician's independence and impose conformity in his management of patients. Critical analysis of the use of acute beds should lead to a relative increase in beds and reduced costs. It will, however, point to the need of extended care facilities and home care.

Physicians should not themselves do the major share of the reviewing but lay personnel should be so trained. Effective review must be accomplished while the patient is in the hospital. Based on facts already assembled, physicians could then judge questionable cases. The insurance carriers will pay physicians $25 per hour or $12.50 per case divided among the review panel.

That non-physicians can be trained for valuable medical service is exemplified by nurses in coronary care units. We were concerned that recruiting nurses as physicians' assistants deprives the nursing ranks of valuable personnel. Medical corpsmen discharged from the Armed Forces form a valuable untapped resource.

Rural scholarship recipients should be those desiring general practice and be so obligated for a specified time. Counties short of physicians might request a place in one of the Ohio medical schools and provide a scholarship for that place. Continued communication between the sponsor and the student would maintain interest.

Welfare patients are told they have the choice of physicians but, in seeking a physician, many are not accepted. The state fee of 60 percent is one factor, but more important is the overworked physician who may not accept new patients, *regardless of ability to pay*. This is noted particularly in areas where new industry brings many new people.

A welfare rights organization was reported in which the concept is held that the patient has the "right not to be sick" rather than the right to medical care. The group's legal counsel represents this to the providers. Expectations are encouraged on the part of the patient which cannot be fulfilled. Physicians should be concerned with treating the poor but patient's overexpectations and physician's impatience impair this relationship.

By Robert A. Bruce, M.D., Dayton

Our group considered medical education, fee review, medicare and medicaid, malpractice insurance and town gown medical student — hospital relations.

The method of selection of medical students remained a mystery to us. None of us felt that we had any idea of how medical students are selected. The group was unanimous in the opinion that a program in the socio-economics of medicine should be included in the medical schools, and graduate programs, emphasizing the attractiveness of private practice as a career in medicine in addition to teaching or research.

Fee review discussion brought out the existance of available consultants furnished by internal medicine organization in Ohio. It was concluded that other specialty organizations should consider the establishment of such a panel for use as consultants in specific cases involving such a specialty.

There was a divergence of opinion in review of insurance company complaints. Some members felt mediation committees should review such complaints. The writer does not think so. Insurance companies stress "usual and customary fees" in their literature, but in determination of fees, they mean "prevailing" fees. I do not think we should burden mediation committees with insurance company work. In my county we do not.

Town gown, etc., relationship discussion included methods of assimilating faculty members into the local society.

Medicare and Medicaid. — Extended care facilities were discussed. It was concluded that eventually, the determination of length of stay based on diagnosis, will simplify this problem.

Malpractice Insurance — This brought a spirited discussion with high premiums the primary concern. The California law requiring bond by the plaintiff was discussed as was the Canadian Law eliminating contingency fees for lawyers.

It was concluded that nothing probably will be done until it becomes evident that the delivery of health care is jeopardized by the fear of exhorbitant malpractice settlements. It will be dealt with either by the Congress on a national level or by the legislature on the state level.

By Luther W. High, M.D., Millersburg

The group was much concerned with criticism of the profession by news media, particularly newspapers. Medicine is pawn of both political parties. Since organized medicine is unable to present its side through news media, consideration might be given to employment of private public relations organization, who would present medicines side of national health picture.

The individual physician is still the best public relations person but too few take time to discuss problems with patient and political representatives.

Hospital relations between administration and physician are not of the best. Criticism was leveled at hospital administrators but joint conference committees share some of the blame. Too often action of committee and recommendations are not relayed to staff, and decisions are made by lay

administrative personnel with little regard for medical problem.

Consideration should be given to establishment of a statewide relative value schedule, permitting private insurance companies to establish premium for insurance to cover outpatient and office care. Prepayment plans handled through private companies might combat labors plans.

Younger physicians must be given continuing responsibility in organized medicine and hospital organization. Too many physicians are inactive in associations, making it difficult for medicine to present united front in providing medical care. Physicians must become involved in comprehensive and environmental health programs. Failure to do so gives professionals in these fields, and laymen, free hand to set up programs which may not be medically sound.

Malpractice insurance continues to be a problem, forcing some physicians to alter practice. Better liaison between legal and medical profession, discontinuance of contingency fee, could solve problem.

Physicians must be alerted that once Medicare assignment is accepted, this constitutes full payment, and no additional amount may be collected from patient, other than the 20 per cent of the fee not paid by medicare.

Comment was made concernng *OSMA Journal.* It was felt that improvement could be made in this publication as a scientific journal. Consideration might be given to a bi- or tri-state *Journal,* so as to induce publication of more scientific articles.

The group felt strongly that medical schools should give full academic credit for preceptorship experiences.

By John H. Budd, M.D., Cleveland

Health care costs and what physicians can do about them.

A. Those under M. D. control—

a. fees

b. hospital admissions, tests, long stays

a. Excessive fees are now and should continue to be prevented and remedied by mediation committees and peer review. These mechanisms should be supported.

MD fees are but a small part of total health care costs.

In Medicaid, MD fees constitute 11 percent of bill nationally; 7 percent of bill in Ohio.

That is, if MD fees were completely eliminated, the national Medicaid bill of $3 billion would be reduced only to $2.7 billion, and in Ohio 93 percent of the present cost would remain unchanged.

b. Excessive number of tests, doubtfully necessary admissions, excessively long stays are often the result of physicians practising "defensive medicine" because of medicolegal risks of lawsuit.

Publicity re nationally known personalities entering hospital for periodic "checkup" suggests to average patient that he should get his checkup in hospital also.

Some health and accident policies provide earlier and more generous disability benefits if policy holder is hospitalized rather than remaining an outpatient.

Savings may be possible through lab and X-ray testing, and multi-channel screening tests etc. on outpatient basis.

B. Those not under MD control- especially hospital costs, drug costs.

Of hospital costs, 70 percent is labor.

Individual hospital employe wages are not high, really rather low.

With 3 employes per patient though, an individual wage scale of $2/hr. amounts to $6/hr. of wage costs for that patient ($48 for an 8 hr. day).

With unionization a probability further cost increases seem certain.

Question was raised whether proprietary hospitals may operate at less cost with utilization control by profit incentive. (Note risk of reduced quality care by under-utilization if control too stringent.'

Recommendations arising out of group discussions:

1. Protection against legal hazards of unjustified liability suits.

2. Review and maybe revision of insurance practice of automatic increase in benefits for patients who are hospitalized.

Comments—Impact of insurance is to increase costs.

Increase in insurance seems inevitable, and generally desirable.

There was disagreement on merits of first dollar coverage.

Utilization and Cost are currently problems in Medicare and Medicaid; if unlimited National Health Service is launched chaos will result and a problem become a disaster.

Annual Physical Examination And Its Merits.

1. Numerous disorders are undetectable at treatable stage.

2. Effective treatment of others is unavailable even if discovered early.

3. Some detected are trivial.

4. Advice given as result of physical is often poorly followed, useless, (reduce weight, avoid excesses in alcohol, tobacco, etc.)

Acknowledging these limitation, annual physicals however, have value, especially for those over age 40.

Health Care of Needy People.

There are those who receive less than adequate health care; there are a variety of reasons, of which many are social rather than medical.

It is important to make it clear to the public what is POSSIBLE to do, not just what SHOULD be done.

Continuity of care is a defect in care of the needy and is also a problem in the current system of health care generally.

Nonphysician Assistants

Impromptu poll of the group on propriety and acceptance of certain selected services proposed for delegation to non-physicians.

There was majority agreement on their use as surgical assistants in OR; drawing blood; catheterizing; starting IV's; removing casts, applying casts in stable undisplaced fractures.

There was substantial support for their use in-routine prenatal exams; well baby examinations including immunization; house calls to evaluate patient and the need for physician to come or see pt.

Either very limited approval or complete rejection of their use inhistory taking; physical examination, delivery of uncomplicated OB cases; anesthesia administration in "simple" cases.

Final Comments

A major cause of current turmoil and dissatisfaction is the over-promising of unattainable (however desirable) objectives and their inevitable under-delivery.

We wish legislators and others who may criticize our profession could have attended group session and witnessed the earnest, well-intentioned proceedings.

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

IT'S MID-YEAR ON THE CALENDAR but end-of-the-year for many auxiliaries. June-August means a brief respite from organization affairs for many. Here's hoping you can find time for a family-type vacation this summer or a few days of togetherness for Mom and Dad while the kids are off at camp.

Let's look back over the last batch of Auxiliary Newsletters to see how the year closed for our counties. There were numerous "changes of the guard" as new officers were installed. State officers participated in some of these — Mrs. S. L. Meltzer attended the annual meeting of the Erie County Auxiliary on May 19 at the Plum Brook Country Club. Mrs. Carl F. Goll was the installing officer for the Stark County Auxiliary at its annual meeting in April.

Erie County Reports

Erie County auxilians had the opportunity recently to learn more about two of their prime projects. The Auxiliary has been interested in drug education for the community and this past year had purchased the film "Marijuana" for use by any groups in the area. A committee was formed to promote the showing of the film by organizations. However, the committee chairman, Mrs. H. L. Hoffman, felt that individual members were not really familiar with drugs and probably would not recognize them.

Mrs. Hoffman arranged for the Auxiliary to meet with an officer of the Erie County Sheriff's Department to see actual drug samples picked up by the department. The officer also displayed equipment used by heroin addicts and answered questions about current local drug activity. Members were particularly interested in this situation as it might affect their own families.

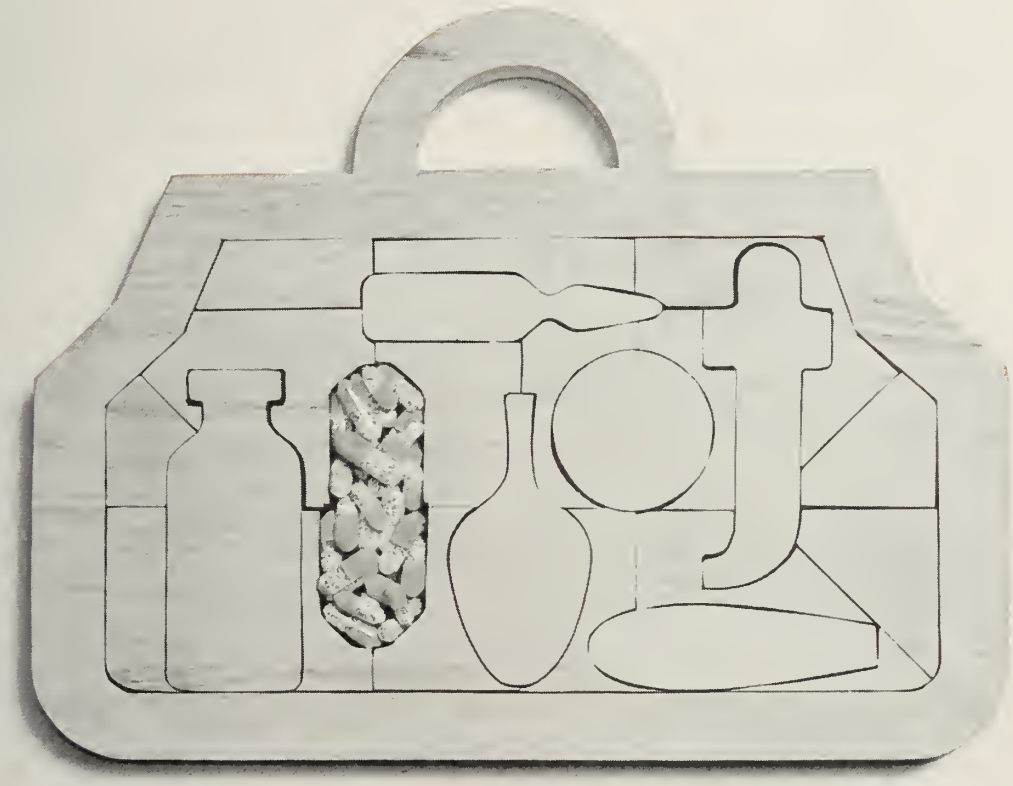
Another major concern of the Erie County Auxiliary has been the promotion of health careers. Erie County is fortunate to have the Sandusky School of Practical Nursing located in Sandusky, the county seat. Although this school has been in operation for twelve years, most auxiliary members knew very little about it. Mrs. Dean E. Sheldon, whose late husband was instrumental in the school's founding, was concerned with this lack of knowledge and arranged for a tour of the school. The school's director, Katherine Rudy, R.N., spoke to the visitors and explained the program and facilities.

The Sandusky School of Practical Nursing is sponsored by the Board of Education. Classes during the 18-week pre-clinical period are held in the Board of Education building which houses the school. The students spend their 34 weeks of clinical training at one of the affiliating hospitals: Good Samaritan, Providence and Memorial Hospitals in Sandusky, and Fisher-Titus Hospital in Norwalk. Auxiliary members are quite enthusiastic about the practical nursing school and plan some form of aid in the future.

Mock Disaster Involves Handicapped

The annual mock disaster exercise, sponsored by the Academy of Medicine of Cincinnati and the Hamilton County Office of Civil Defense, was held Saturday morning, May 9, at the St. Rita School for the Deaf. More than 100 students of the school participated as simulated casualties resulting from a "fire" at the institution. They were "made up" by the Cincinnati College of Mortuary Science for injuries such as burns, smoke inhalation, fractures, shock, superficial abrasions and lacerations.

The purpose of the exercise was to increase the capabilities and develop coordination of all participating emergency services. Life squads and fire departments from neighboring communities were involved in deploying the casualities to the various hospitals in the area. Members of the Woman's Auxiliary to the Academy of Medicine



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of Cincinnati assisted the Red Cross in registration of all participants in the mock disaster exercise. Mrs. Denis F. Cash, Disaster Preparedness and Safety chairman, recruited volunteers from the Auxiliary.

Activities in Stark County

Mrs. Frank Weinstock has announced that ten members of the Board of the Women's Auxiliary to the Stark County Medical Society have volunteered to walk in the GOLD RUSH WALK. This is an annual fund raising event sponsored by a number of organizations in Canton. Particpats "earn" money on the basis of the number of miles walked.

A Suicide Prevention and Crisis Assistance Center is being organized in Canton. It will provide 24 hour emergency service for anyone with a problem. A six-week course of 4-5 hour sessions weekly is being offered to train volunteers. Auxiliary members will cooperate in this community venture.

Officer Roster

For the benefit of those who wish to correspond with the 1970-1971 officers, the following new roster is presented:

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President—Mrs. Carl F. Goll, 1001 Granard Parkway, Steubenville, 43952.

President-elect—Mrs. Russell L. Wiessinger, 2280 W. Wayne Street, Lima, 45805.

Past-President—Mrs. Samuel L. Meltzer, 2442 Dorman Drive, Portsmouth, 45662.

First Vice President—Mrs. Rudolf O. Cooks, 15830 Van Aken Blvd. Apt. 401, Shaker Heights, 44120.

Second Vice President—Mrs. Daniel Wolff, 3963 W. Bancroft Street, Toledo, 43606.

Third Vice President—Mrs. H. I. Humphrey, 389 S. Drexel Avenue, Columbus, 43209.

Recording Secretary—Mrs. Emil L. Barrows, 7181 West Aracoma Drive, Cincinnati, 45237.

Corresponding Secretary—Mrs. F. A. Sunseri, 301 Woodridge Drive, Steubenville 43952.

Treasurer—Mrs. Paul Hahn, 122 Moore Avenue, N.W., New Philadelphia, 44663.

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County Societies' Officers and Meeting Dates

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High St.

ADAMS—Gary J. Greenlee, President, Farmers' Bank Building, Manchester 45144; Hazel Sproull, Secretary, P.O. Box 337, West Union 45693, 3rd Thursday, April, July, Oct. and Jan.

BROWN—Robert S. Benintendi, President, South Main Street, Route 1, Box N, Georgetown 45121; Robert A. Baker, Secretary, South Main Street, Georgetown 45121.

BUTLER—John H. Varney Jr., President, 3207 Sheldon Rd., Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, P.O. Box 325, 110 North Third St., Hamilton 45011. 4th Wednesday.

CLERMONT—Kurt Platschik, President, 4450 Mt. Carmel-Tobasco Road, Cincinnati 45244; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103; 3rd Wednesday except July, August and December.

CLINTON—Arthur F. Lippert, President, 110 East Locust St., Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday.

HAMILTON—Robert S. Heidt, President, 2340 Auburn Ave., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday, except June, July, Aug. and Dec.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson St., Greenfield 45123.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason 45040; Orville L. Layman, Secretary, 22 West Fourth St., Franklin 45005. 2nd Tuesday.

Second District

Councilor: George J. Schroer, Ft. Loramie 45845
20 S. Main St.

CHAMPAIGN—Lewis Inskeep, President, 201 Scioto St., Urbana 43078; Terrence F. Grogan, Secretary, 848 Scioto St., Urbana 43708. 2nd Wednesday.

CLARK—Wesley E. Knaup, President, 1054 East High St., Springfield 45505; Mrs. Marion Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone St., Springfield 45503. 3rd Monday, except June, July, Aug. and Dec.

DARKE—E. W. Browne, President, 330½ West Fourth Street, Greenville 45331; Giles Wolverton, Secretary, Health Department, Court House, Greenville 45331. 3rd Tuesday.

GREENE—Rudi Sotlar, President, 12 South Limestone Street, Jamestown 45335; Mrs. W. F. Whitt, Executive Secretary, 966 Whitestone St., Xenia 45385. Last Friday of every month.

MIAMI COUNTY—Kenneth Faze, President, 3 Duerr Drive, West Milton 45383; Martha L. Derr, Executive Secretary, P.O. Box 467, Piqua 45356. 1st Tuesday.

MONTGOMERY—Robert A. Bruce, President, 1126 South Main St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. Monthly meeting dates as established.

PREBLE—J. D. Darrow, President, 228 North Barron St., Eaton 45320; J. R. Williams, Secretary, 228 North Barron St., Eaton 45320. No regular meeting date.

SHELBY—George J. Schroer, President, 20 South Main St., Fort Loramie 45845; William F. Menteges, Secretary, 870 South Main Ave., Sidney 45365. 2nd Tuesday of March, June, September and December.

Third District

Councilor: Dwight L. Becker, Lima 45805
1559 Bunker

ALLEN—Alexander C. Reed, President, 819 West North St., Lima 45801; William E. Noble, Secretary, c/o Memorial Hospital, Linden & Mobel Ave., Lima 45804. 3rd Tuesday.

AUGLAIZE—John F. Bowling, President, N. Knoxville Rd., St. Marys 45885; Barbara Cummins, Secretary, 310 Perry St., Wapakoneta 45895. 1st Thursday every other month, starting with January.

CRAWFORD—Horace B. Newhard, President, 140 Hill St., Bucyrus 44820; C. Fabrigar, Secretary, 139 Gaius St., Bucyrus 44820. Meeting date variable.

HANCOCK—Robert Brown, President, 868 South Main St., Findlay 45840; Truman S. Smith, Secretary, 145 West Wallace St., Findlay 45840. 1st Tuesday monthly.

HARDIN—Jay Pfeiffer, President, 215 Main St., Kenton 43326; John Hughes, Secretary, 601 Pattison Ave., Kenton 43326. 2nd Tuesday evening monthly.

LOGAN—Donald Wyse, President, Oakhill Medical Association, West Liberty 43357; Douglas W. Beach, Secretary, 1008 North Main St., Bellefontaine 43311. 1st Friday monthly.

MARION—John E. Aiken, President, 1040 Delaware Ave., Marion 43302; Brooks Sitterly, Secretary, McKinley Parkway Dr., Marion 43302. 1st Tuesday monthly.

MERCER—George H. McIlroy, President, 123 East Fayette St., Celina 45822; D. J. Schwieterman, Secretary, Rolfes Rd., Maria Stein 45860. 3rd Thursday.

SENECA—Leroy Cummings, President, 60 Sycamore St., Tiffin 44883; Donald Shanabrook, Secretary, 455 West Market St., Tiffin 44883. 3rd Tuesday evening Jan., March, May, July, Sept. and Nov.

VAN WERT—Thomas R. Wilson, President, Van Wert County Hospital, Van Wert 45891; Robert Scheidt, Secretary, Medical Arts Building, Van Wert 45891. 4th Friday.

WYANDOT—D. P. Smith, President, Pennington St., Sycamore 44882; K. K. Solacoff, Secretary, 777 North Sandusky Avenue, Upper Sandusky. 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43624
316 Michigan St.

DEFIANCE—Jack A. Kane, President, Central Foundry, Defiance 43512; Miss Lois Coffin, Executive Secretary, Defiance Hospital, Defiance 43512. 1st Saturday.

FULTON—R. L. Davis, President, 137 South Fulton St., Wauseon 43567; M. S. Renfrew, Secretary, Lutz Rd., Archbold 43502. Quarterly meetings March, June, Sept. and Dec.

County Society Roster (continued)

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545.

LUCAS—Roland L. Kennedy, President, 4639 Farmington Rd., Toledo 43623; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday,

OTTAWA—Donald F. Loeffler, President, 521 East Second St., Port Clinton 43452; Gordon R. Ley, Secretary, P. O. Box J, Port Clinton 43452. 2nd Thursday evening monthly.

PAULDING—Kirkwood A. Pritchard, President, 119 South Main St., Paulding 45879; Don K. Snyder, Route #2, Paulding 45879. 3rd Monday monthly at the Paulding County Memorial Hospital.

PUTNAM—Arthur P. Daniel, Secretary, 144 North Walnut St., Ottawa 45875. 1st Tuesday.

SANDUSKY—Allen Schaengold, President, 325 South Park Ave., Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday.

WILLIAMS—P. G. Meckstroth, President, Central Drive, Bryan 43506; S. O. Cooper, Secretary, Central Drive, Bryan 43506. 3rd Tuesday.

WOOD—William Roberts, President, North Baltimore 45872; William F. Lord, Secretary, 950 West Wooster St., Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: P. John Robechek, Cleveland 44122
3461 Warrensville Center Rd.

ASHTABULA—W. B. Millberg, President, 430 West 25th Street, Ashtabula 44004; Miss Dorothy L. Geho, Executive Secretary, P.O. Box 205, Geneva 44041. 2nd Tuesday.

CUYAHOGA—Vincent T. LaMaida, President, 4125 Mayfield Rd., Cleveland 44121; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106. Board meets 2nd Tuesday.

GEAUGA—Oscar Brinckmann, President, 12475 Hospital Dr., Chardon 44024; Mrs. Ruth Milgate, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024. 2nd Friday.

LAKE—John J. Cahill, President, 36001 Euclid Ave., Willoughby 44094; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060. 4th Wednesday of Jan., March, May, Sept. and Nov.

Sixth District

Councilor: Maurice F. Lieber, Canton 44703
515 Third St., N. W.

COLUMBIANA—John A. Fraser, President, 403 Little Building, East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460. 3rd Tuesday monthly.

MAHONING—Robert L. Jenkins, President, 21 Wickliffe Circle, Youngstown; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44505. 3rd Tuesday, except June, July and August.

PORTAGE—Kenneth F. Rupp, President, 9160 State Route 43, Streetsboro 44240; Miss Maria Motyka, Executive Secretary, 430 Grant St., Akron 44311. 3rd. Tuesday.

STARK—Frank O. Goodnough, Room 615, President, Peoples-Merchants Trust Building, Massillon 44646; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday.

SUMMIT—Edwin W. Cauffield, President, 505 Ohio Building, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 2nd Tuesday, excluding July and August.

TRUMBULL—J. R. Phillips, President, St. Joseph's Hospital, N. Tod Avenue, Warren 44485; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday, September through May.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth St.

BELMONT—Thomas L. Ring, President, 3205 Belmont Street, Bellaire 43906; Bertha M. Joseph, Secretary 100 South 4th Street, Martins Ferry 43935. 3rd Thursday, except January, May, July and August.

CARROLL—T. J. Atchison, President, 292 East Main St., Carrollton 44615; Jack L. Maffett, Secretary, 264 South Lisbon St., Carrollton 44615. 3rd Tuesday.

COSHOCTON—Myron Saturski, President, 149 South Bridge Street, Newcomerstown 43832; Robert W. Secrest, Secretary, 1926 Melbourne Road, Coshocton 43812. 2nd Tuesday.

HARRISON—R. W. Weiser, President, Jewett 43986; Janis Trupovnieks, Secretary, Hopedale 43976. Quarterly, March, June, Sept. and Dec.

JEFFERSON—Crist G. Strovilas, President, 812 North Fourth St., Toronto 43964; Mrs. Mary Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952. 4th Tuesday, except Aug. and Dec.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—P. T. Doughten, President, 551 Wabash Ave. N. W., New Philadelphia 44663; M. R. Puterbaugh, Secretary, 104 Iron Ave., Dover 44622.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson

ATHENS—Dale Mattmiller, President, Hudson Health Center, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. Second Tuesday except July and August.

FAIRFIELD—R. A. Welsh, President, Lancaster-Fairfield Hospital, Lancaster 43130; C. R. Reed, Secretary, 309 East Main Street, Lancaster 43130. 2nd Tuesday.

GUERNSEY—Merritt C. McCuskey, President, 1200 Edgeworth Ave., Cambridge 43725; Quentin F. Knauer, Secretary, 100 Clark Ct., Cambridge 43725. 1st Tuesday monthly, 7 P.M., Cambridge Country Club.

LICKING—Edward A. Carlin, President, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055; G. Franklin Gabe, Secretary, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055. 4th Tuesday monthly.

MORGAN—Asa Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 East Union Ave., McConnelsville 43756.

MUSKINGUM—James F. Morton, President, 727 Market St., Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Ave., Zanesville 43701. 1st Tuesday.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Box 39, Caldwell 43724. 1st Tuesday.

County Society Roster (continued)

PERRY—A. G. Cruz, President, 203 North Main St., New Lexington 43764; R. E. Herendeen, Jr., 203 North Main St., New Lexington 43764.

WASHINGTON—Gregory B. Krivchenia, President, 326 Third St., Marietta 45750; Donald E. Fleming, Secretary, Vincent 45784. 2nd Wednesday monthly.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—Arturo de Lamerens, President, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631; Donald M. Thaler, Secretary, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631. Quarterly meetings at call of officers.

HOCKING—Lethia W. Starr, President, 109 Mulberry St., Logan 43138; J. W. Doering, Secretary, 42 North Spring St., Logan 43138. 2nd Tuesday monthly.

JACKSON—Earl Levine, President, 120 North Ohio Avenue, Wellston 45692; John M. Cook, Secretary, Box 316, Oak Hill 45656. Meetings when called.

LAWRENCE—A. Burton Payne, President, 411 Center Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly meetings.

MEIGS—Charles J. Mullen, President, 210½ East Main St., Pomeroy 45769; E. Butrimas, Secretary, 204 East Main St., Pomeroy 45769.

PIKE—W. W. Wiltberger, President, 330 East North St., Waverly 45690; Thomas Hwang, Secretary, 300 Cherry St., Waverly 45690. 1st Tuesday monthly.

SCIOTO—Joseph T. Gohmann, President, Scioto County Medical Society, Portsmouth 45662; Mr. Lowell Thompson, Executive Secretary, 1805 27th St., Portsmouth 45662. 6:30 2nd Tuesday.

VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050
104 E. Gambier St.

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HOLMES—Daniel J. Miller, President, Walnut Creek 44687; Charles H. Hart, Secretary, 109 South Clay St., Millersburg 44654. First (or Second) Thursday 7 P.M. (Sometimes it may follow hospital staff meeting.)

HURON—John E. Rosso, President, 218 Myrtle Ave., Willard 44890; Russell R. Fisher, Secretary, 257 Benedict Ave., Norwalk 44857. 2nd Wednesday of February, April, June, October and December.

LORAIN—Robert P. McFarland, President, Oberlin Clinic, Inc., 224 West Lorain Street, Oberlin 44074; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday for REGULAR MEETINGS. Last Thursday of the month for COUNCIL MEETINGS.

MEDINA—H. E. Grover, President, 146 North Lyman Street, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 320 East Liberty Street, Medina 44256. 3rd Thursday.

RICHLAND—Robert W. Jones, President, 120 Sturges Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, c/o Mansfield General Hospital, Mansfield 44903. 3rd Thursday except June, July and August.

WAYNE—Frank Cebul, President, 1740 Cleveland Road, Wooster 44691; Thomas Graves, Secretary, 1740 Cleveland Road, Wooster 44691. 2nd Wednesday of alternate months.

For Roster of OSMA Officers and Committeemen See Revised Listing in the July Issue

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

EXCELLENT OPPORTUNITY: Large industrial private medical practice, Southwestern Ohio, wishes associate. Reply Box 547, c/o Ohio State Medical Journal.

GENERAL PRACTITIONER OR INTERNIST — Full-time staff physician needed for Domiciliary Medical Service in 732 bed general medical and surgical hospital. Ohio State University Medical College affiliation. Faculty members conduct conferences, clinics, and participate in a diversified residency training program. Medical license in any state acceptable; salary range $18,531 to $23,029 per annum depending upon qualifications. Maximum leave and insurance benefits; non-citizens will be considered; nondiscrimination employment. Write: Center Director, Veterans Administration Center, 4100 West Third Street, Dayton, Ohio 45428.

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WANTED: a capable General Practitioner to assume my lucrative private practice. Retiring—Can gross over $50,000. Share second floor with dentist over a drug store. No money involved. Come to work—Large progressive Northern Ohio city. Reply Box 597 c/o The Ohio State Medical Journal.

GENERAL PRACTITIONER OR INTERNIST—Available immediately. Busy practice for G.P. or Internist desiring family practice without Obstetrics. Group consists of 3 G.P.'s and Surgeon, in new building with lab and x-ray facilities. Local 50 bed J.C.A.H. approved hospital. Rural area with excellent school system. Ready access to Cleveland, Akron, Columbus. No investment. Early partnership. Housing available. Reply John A. Grafton, Business Mgr., Lodi Medical Building, 402 Highland Dr., Lodi, Ohio 44254 or phone (216) 948-1555.

PSYCHIATRISTS: Avoid pollution enjoy fresh air, clean water, less people in a summer-winter vacationland near Interlochen Arts Academy. Small town peace and quiet. Big city culture and salaries. Progressive psychiatric hospital, J.C.A.H. approved, 3-year Psychiatric Residency Program. Salaries to $32,364 if you qualify, excellent fringes, housing available. Contact M. Duane Sommerness, M.D., Traverse City State Hospital, Traverse City, Michigan 49684.

UNIVERSITY STUDENT HEALTH PHYSICIANS: Two immediate openings, Northwest Ohio. 13,000 students, modern new facilities, 102 bed hospital and complete lab. & x-ray facilities; excellent salary, fringe benefits, vacation, and working conditions. Reply Box 590, c/o The Ohio State Medical Journal.

EMERGENCY ROOM PHYSICIAN — full or part time. High salary. Contract leading to partnership. Active, acute medical and traumatic service. No pediatrics. Ohio License required. Contact F. C. Witwer, M.D., Akron General Hospital, 400 Wabash Ave., Akron, Ohio 44307.

CINCINNATI—New office opening this year in Finneytown area, plan your space now. Contact: C. H. Schapera, M.D. 931-5555.

GENERAL PRACTITIONERS AND INTERNISTS: Opening with group of seven physicians seeking future partners in area serving Elyria, Lorain and Cleveland. Third fastest growing area in the state. Excellent opportunity with high starting salary. Call Cleveland (216) 777-5190, Lorain (216) 233-6121 or Elyria (216) 365-7311.

CANTON, OHIO—Desire physician in new medical office with approx. 1,100 sq. ft. of carpeted area. Bldg. is owned and occupied by dentist in prestige area with high caliber clientel in need of a physician. Will give reasonable rent. Inquire: Ernest Pagonis, D.D.S., 1200 48th Street N. W. Canton, Ohio 44709. Telephone 494-9244.

OPPORTUNITY: Young associate for very busy General Practitioner in new medical building, established practice, lab & x-ray facilities, nearby 110-bed ECF, also open staff hospital facilities, growing community between Cleveland and Akron. Salary commensurate with training and experience. Write Box 602, c/o The Ohio State Medical Journal.

WANTED: Physician to engage in general practice at Geneva-on-the Lake, Ohio, summer resort, and operate the emergency room service of Geneva Memorial Hospital from June 1st or July 1st to Sept. 8th, 1970. Furnished home and office at Geneva-on-the-Lake. Rent free. No investment. Phone Geneva 466-3424 or write Dr. James A. Talbot, 681 East Main St., Geneva, Ohio 44041.

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G.P. wanted Northcentral Ohio. Urban. Contract leading to partnership. Excellent practice including OB, new modern office. 250-bed hospital open staff, adjacent. Private practice with congenial group in association. Reply Box 609 c/o Ohio State Medical Journal.

Central Ohio G.P. desires Associate leading to partnership. Urban-rural. Open staff 180-bed hospital 9 miles, capacity being increased to 250. Reply Box 608, Ohio State Medical Journal.

HEALTH COMMISSIONER: Greene County, Southwest Ohio, well established county unit, population 135,000, (located near Dayton, Cincinnati, Columbus.) Competent staff of 45. Programs include diversified clinics, Home Care, Environmental Health. Requirements: M.D. with Ohio Licensure, Public Health Training and/or experience preferred. Salary open — $22,000 plus, and fringe benefits. Write or phone Dr. Robert Englefield, President, Board of Health, 120 Miami Dr., Yellow Springs, Ohio 45387 — phone — 513-767-7991.

GP WANTED in Lakeside-Marblehead area in the heart of Ohio's Lake Erie Vacationland. More than 4,000 residents, many more May through October. Excellent modern 132-bed hospital within 10 miles. A scenic area with boating, fishing, hunting, golf and other recreation. Write: Peninsula Chamber of Commerce, att'n C. H. Wolfe, P. O. Box 268, Marblehead, Ohio 43440.

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PSYCHIATRIC RESIDENCY — modern 120 bed hospital in Akron suburb, 40 mins. from Cleveland; comprehensive 3 yr. approved program. Area growing; high demand for psychiatrists. M. Menassa, MD., DME, Fallsview Mental Health Center, Cuyahoga Falls, Ohio 44222 (216) 929-8301.

OFFICE AND EQUIPMENT for lease or sale; Columbus, W. Broad St. on Hilltop; write G. F. Millay, M.D., 2085 Northwest Blvd., Columbus, O. 43221; or call 614-486-7722.

PHYSICIAN/MEDICAL DIRECTOR — Coordinate volunteer physician services, supervise medical activities of University Circle area free medical/drug treatment clinic, starting in June. Specialty unimportant; drug work desirable. Half days free. Approximately $10,000. Write or call Mr. Gordon Friedman, Director, Free Medical Clinic, 1337 National City Bank Bldg., Cleveland, 44114.

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FOR RENT: Physician's office, furnished or unfurnished, with patients' records; practice still active; no cash or sale required; splendid chance for young internist or GP; 1,000 sq. ft.; new building. W. D. Paul, M.D., 2691 E. Main St., Columbus, Ohio (Bexley).

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EMERGENCY ROOM PHYSICIAN — Full or part time; $25,000 per year plus percentage 40 hr. week; Ohio license required; Contact John N. Bartone, M.D., Elyria Memorial Hospital, 630 East River Rd., Elyria, Ohio 44035.

WANTED: Physician to head up medical department for large automobile manufacturing plant in N.C. Ohio with approximately 3500 employees. Full time position with best employee benefits, including a new car provided. Reply Box 612 c/o The Ohio State Medical Journal.

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EMERGENCY ROOM PHYSICIANS — Needed to staff major, well equipped, JCA approved, 500 bed hospital in Dayton, Ohio; permanent position, full or part time; salary and hours negotiable; fringe benefits; liberal working conditions; Ohio State License required. Contact: Nicolo Mileti, M.D., Director of Emergency Service, Box B. Dayton View Station, Dayton, Ohio 45406.

URGENTLY NEEDED: General Surgeon, Board certified or qualified, experience in Orthopedic, GYN, and Trauma is desirable. Modern 32 bed hospital located in rural north central Ohio with drawing area of 10,000-12,000. Excellent schools, economically stable community. Equipped office available for immediate occupancy. Excellent opportunity exists for an additional Family Physician. Reply to Box 611 c/o Ohio State Medical Journal.

OFFICE FOR RENT: Cincinnati, Ohio, Mt. Washington. Fine location. Office of Doctor retiring after 38 years in area. Equipment optional. Write or call Paul Cook, 3520 Edwards Road, Cincinnati, Ohio 45208. 1-513 321 9184.

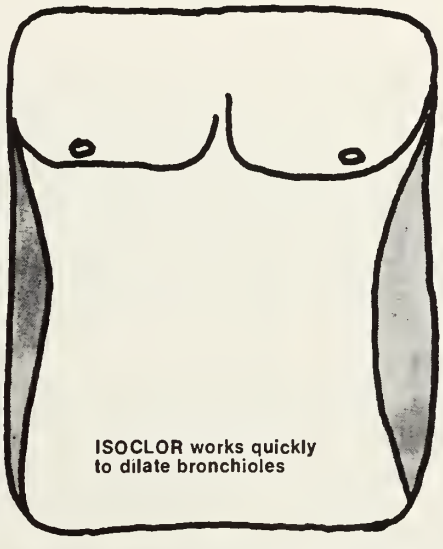
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PROGRESSIVE COMMUNITY near Findlay, Ohio and Blanchard Valley Hospital, needs a G.P. to replace a partner who is leaving July 1, 1970, to take a Residency in Anesthesia. Write or call H. K. Treece, M.D., Arlington, Ohio 45814; phone 365-5413.

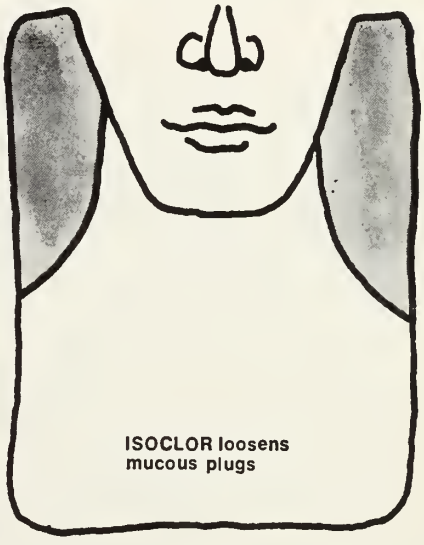
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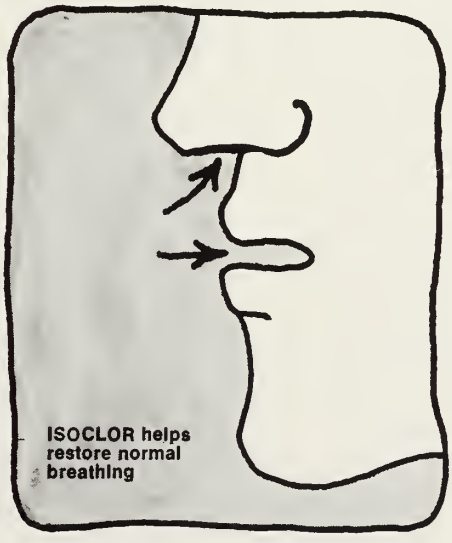
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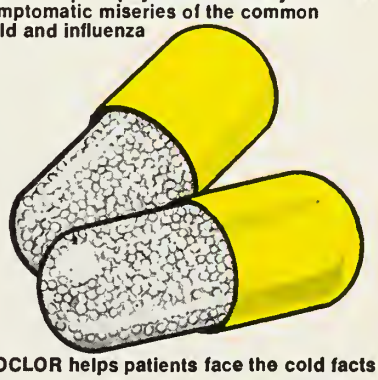


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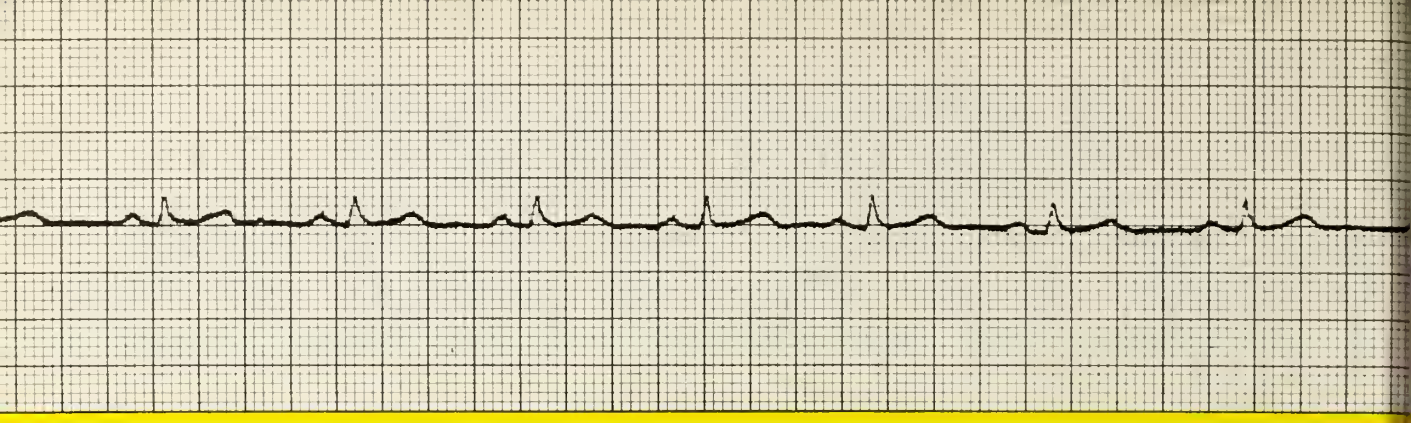
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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JULY, 1970
Vol. 66 • No. 7

The Ohio State MEDICAL JOURNAL

UBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON
3 SEP 1970

The "Positive" Approach



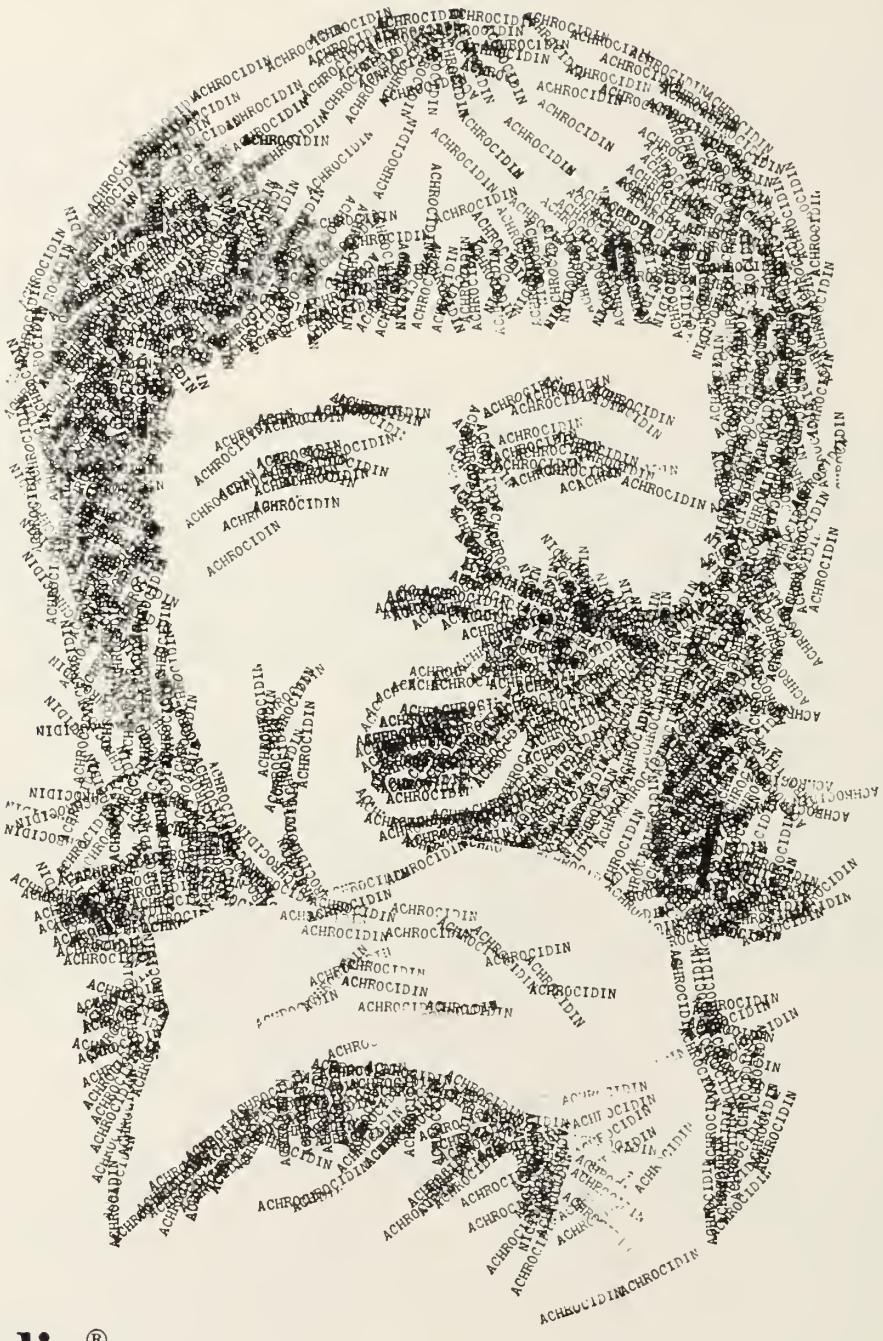
Annual Meeting Headliner Dr. Norman Vincent Peale approaches the auditorium, accompanied by Donald J. Vincent, M.D., Chairman of the OSMA Committee on Medicine and Religion.

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OSMA 1970 Annual Meeting
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Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

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Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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References:
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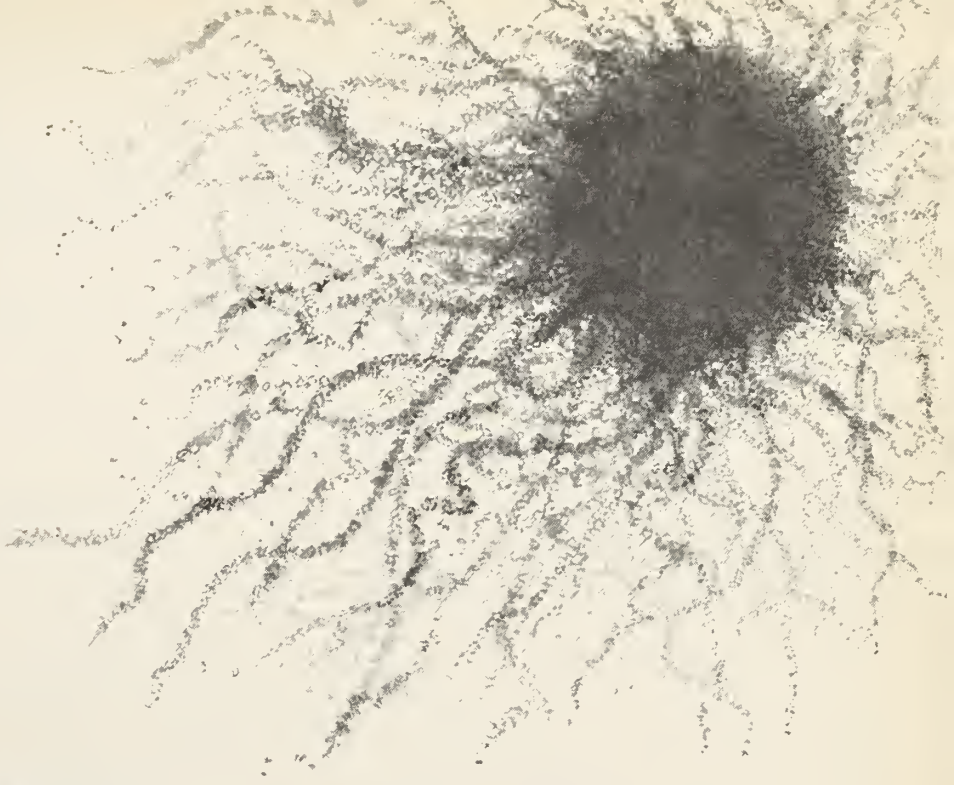
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Corticosteroid therapy week after week.

then antibiotic therapy last week.

and monilial overgrowth this week.

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 448-9

U.S. Census Will Show Where the Growth Is

The 19th Decennial Census will show that America has grown to a land of more than 205 million citizens, according to estimates by statisticians of Metropolitan Life Insurance Company. The Statistical Bureau at Metropolitan indicates that some 203.7 million civilians and members of the armed forces will be counted in the United States.

In addition to the resident total, the United States is expected to have about 1.2 million members in the armed forces overseas and over 600,000 civilians outside the country. The new resident count will represent an increase of about 24.4 million in the decennial period, exceeded only by the gain of virtually 28 million in the preceding intercensal decade.

The 1970 nose-counting, latest in an unbroken series of censuses taken every tenth year since 1790, provides an important profile of the country's growth, determines the size of each state's Congressional representation, and provides basic facts for the annual distribution of billions of dollars of federal and state funds.

The current census is expected to show few changes in trend from those of earlier decades. Most significant may be the record high decennial population growth in the South, in contrast to reduced gains in the other three regions of the country. In fact, the South, which has had a marked upsurge of white immigrants, is expected to have about 63.7 million inhabitants as of April 1. Moreover, its anticipated 8.7 million gain during the 1960's will be well over that in any other region, surpassing the growth in the West for the first time since the 1930's.

Equally noteworthy, the 1970 census is expected to show that California became the most populous state during the past decade. Apparently, California overtook New York around the end of 1963 and, as of this April, may have a lead of over 1.2 million residents.

The 1970 census is expected to confirm that our population continued to grow most rapidly in suburban areas, that growth virtually halted or even reversed in our larger cities, and that slow declines persisted on farms. It should also show that, in the population including the armed forces overseas, the excess of females over males has doubled to almost 4 million, with about three fourths of the current differential among persons at ages 65 and over.

HARDING HOSPITAL

(A Fully Accredited Institution)

WORTHINGTON, OHIO

For the Diagnosis and Treatment of Psychiatric Disorders

and with

Limited Facilities for the Aging

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I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications. For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications. History of sensitivity to meprobamate.

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs, if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient, if persistent and associated with ataxia, usually responds to dose reduction, occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition. Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home an its environs so much.

You can help her over the rough spots with reassurance and counse Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)

Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed

I'll scream if I don't get away!

25 years ago
Ohio Medical Indemnity, Inc.
began under the sponsorship
of the Ohio State
Medical Association.

Today, over 3 million Ohioans
are served by Blue Shield.

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and we Quote

Punch Card Selectivity to Aesculapian Limbo

"(The) dean of the Harvard Medical School, recently said that the salaries of interns and residents should be paid by the federal government, thus giving the government the power to decide who will specialize in what. . . .

"We would not argue, for a moment, that the law of supply and demand is a bit slow on the uptake or that it's from time to time impeded. But nevertheless, we question the wisdom of putting a young man in a kind of Aesculapian limbo and keeping him there for years. Would you have started down the long road to a doctor's degree if you knew that someone in Washington (or worse yet, a computer) was going to select your specialty?" — *American Family Physician.*

Sees Drug Abuse Menace as a "Kidnapper" of Youths

"Thousands of our young people are being kidnapped each year, while parents and community stand by helplessly. The kidnapper is drug abuse, and our children and teenagers are unwittingly following it on dead-end 'trips' to nowhere.

"As parents ourselves, we share the concern of all parents about the drug abuse. And as physicians, we hold a special responsibility to help the community rid itself of this menace. . . ." — Edward W. Cannady, M.D., in the *Illinois Medical Journal.*

Working with the Patient as He Presents Himself

"The patient's religion must be taken into account in any medical care of the whole man, both as regards the direct care of the illness and as regards its psychosomatic effect. In this, we need cooperation and understanding between physician and clergyman.

"The physician's own religious beliefs and his religious commitment are also of importance in the practice of medicine, although they may be nebulous, unformulated, conceivably agnostic or atheistic. The physician must know himself in order to give full service to the patients he attends. He must have some sort of formulated attitude toward the body-and-spirit constitution of his patient, in order to make the proper approach to the medical problem. This is in part necessary because, whatever his own beliefs, he must work with the patient *as he is* and must accept the human individual as he presents himself, and with respect for his beliefs." — Carl B. Lechner, M.D., in *Pennsylvania Medicine.*

What Price Health? Ohio Physician Asks

"Editor, The Wall Street Journal:

"Re, the page-one article 'The Cost of Illness' (May 7):

"As a physician who has been ill for some two-and-one-half years, I can see both sides of the coin. In the case of little Karen and her kidney condition, we must realize that in the past she would have died or become a chronic cripple. What price tag can one put on restoring a child to a healthy and useful life anyway: The price of a car, or of a home, or of a yacht?

"There seems to be a feeling that everybody has an inborn right to the best medical care possible 'at no cost to the individual.' What about food and shelter—don't we have the same right to those? As a matter of fact, how can one separate health from the other two basic rights? And if we have a right to health care, food and shelter for free, what are we working for?"

Henry Bachman, M.D.
McConnelsville, Ohio

Quoted from *The Wall Street Journal,* May 25, 1970.

Medicine, the Whipping Boy of the Phony Crisis

"Crisis conditions must be relative to the general condition which prevailed at some time or place. It is nonsense to suggest that our current

(Continued on Page 657)

Schering

After only one year:

Administered to more people than live in Youngstown and Lima:*



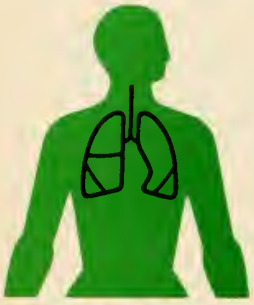
Injectable
Garamycin®
brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Youngstown and Lima is 203,000. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

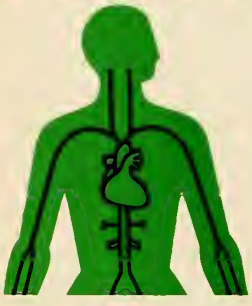
GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus*, coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus*, unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[6]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®
brand of gentamicin sulfate injection

Schering

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentrations of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

Adverse Reactions: The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin in gram-negative urinary and pulmonary infections, Arch. Int. Med. *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., and Smith, J. K.: Gentamicin in the treatment of pulmonary infections, J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a new aminoglycoside antibiotic: Clinical and laboratory studies in urinary tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clinical experience with gentamicin, data from 12 German clinics, in Gentamicin: First International Symposium, Paris, January 1967, Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Laboratory and clinical investigation of gentamicin, *ibid.,* pp. 62-74. (6) Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, H.: Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommended in Package Insert.

For more complete prescribing details, consult package insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28 5-029

crisis is relative to this nation's health-care condition in 1930 or 1900. It is preposterous to suggest that it is relative to the general health care conditions which prevail in Great Britain or India or South America. The widely publicized 'health care crisis' in this nation today is relative only to some utopian dream conjured up by vote-hungry politicians and hard-core socialists. No one can deny that we are encountering problems in continuing to improve the health care for our citizens but these problems do not constitute a crisis and they are not the doing of the medical profession."—*The Journal of the Oklahoma State Medical Association.*

Please Keep This Confidential, Doctor

"Even without such a national data bank, there is precious little privacy left anyway. From the psychological tests given to the elementary school children, to the Army's 201 file, to the records in any court clerk's file, to the credit ratings patiently accumulated, the area of privacy is shrinking. We like to think of our profession as the last bastion of individual privacy, an honor which we hopefully share with the clergyman.

"But how long can we withstand the avalanche of report requests, punch cards, and questionnaires is anyone's guess." —*The Journal of the Medical Society of New Jersey.*

Team Effort Will Offer Spectrum of Medical Skills

"Basically what I am suggesting is that the best medical care of the public is going to be accomplished through a team effort in which a spectrum of medical skills is going to be offered and in which there will be also a spectrum of competence in each field based on education and experience. The leader in this team effort will have to always be a qualified physician as the legal, and the moral, and the ethical responsibility of the patient is his. The physician is entrusted the ultimate responsibility for the patient because of his more extensive training and experience. The physician as team leader will then have a complement of nurses and para-medical personnel to extend the number of patients who are cared for and also to provide treatments that the physician cannot, due to time limitations, and in many instances the nurses and para-medical personnel can perform better anyway."—Alfred Kahn, Jr., M.D., in the *Journal of the Arkansas Medical Society.*

More Responsibility for Medical Aides

"What has happened in the past decade to create new problems and changing roles for physicians and nurses in hospital medical care? For one thing, we have experienced a need for recovery rooms and intensive care units as a result of a greater volume of major surgery and a greater number of severely ill patients. These units have made it mandatory to train personnel to monitor these patients. Registered nurses have been trained to move up into a position of responsibility and decision making, that a few years ago was considered within the realm of the physician. Aides and technicians have been trained to do many of the jobs done previously by the nurse."—James H. Young, M.D., in *The Journal of the South Carolina Medical Association.*



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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association

Cincinnati Will Host Congress of Medical Societies

The Congress of County Medical Societies has announced the dates for its 1970 Annual Meeting and Seminar on Private Practice. The meetings are scheduled for November 6-7-8, 1970, at the Netherland Hilton Hotel in Cincinnati.

The program will feature Mr. Robert J. Myers, Chief Actuary for the Social Security Administration, as the speaker for the Friday, November 6 banquet.

The Congress of County Medical Societies was formed in 1965 as a mechanism for the exchange of information among practicing physicians and their local medical societies. Currently, 70 county societies participate as members and more than 63,000 physicians belong to the organization, making it the second largest medical organization in the country.

The Academy of Medicine of Cincinnati will act as host for the November meeting. Dr. Richard Fulton, President of the Ohio State Medical Association, will be the keynote speaker.

Licensed physicians and all medical society personnel are invited to attend.

Mail address of the organization is P. O. Box 54571, Terminal Annex, Los Angeles, Calif. 90054.

State Agency Physicians to Meet in Lima

The summer meeting of the Association of Physicians of the State of Ohio is scheduled to be held on July 10 at the Lima State Hospital, beginning with registration and coffee from 9:00 to 10:00 a.m. The program begins at 10:00 a.m.

Features of the meeting include the following:

"All Murderers Are Mentally Ill?" by Theodore J. Reshetylo, M.D., clinical director of Lima State Hospital.

"Mental Illness in the Viewpoint of the Law," by the Honorable John D. Harnishfeger, Judge of the Allen County Common Pleas Court.

Martimer Hacker, M.D., president, will preside. Additional information about the organization may be obtained from Virginia S. Edwards, M.D., Secretary-Treasurer, 347 Lexington Ave., Mansfield 44907.

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- Up to $1000 a month Practice Overhead Expense Insurance to pay your office expenses while you're disabled due to accident or illness.

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Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.



With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

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A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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Physician's Bookshelf..

A History of Preventive Medicine, by Harry Wain, M.D., M.S.P.H., *Charles C Thomas Publisher,* 301-327 E. Lawrence Ave., Springfield, Illinois. ($14.75)

In this book the author dramatically compresses five thousand years of progress in preventive medicine into a single volume and concludes with the miraculous story of modern medicine's conquest of contagion.

Beginning with primitive man, the author traces efforts toward preventive medicine through the Hebraic health code, the Golden Age of Greece, pioneers of public sanitation of the Roman Empire, the lessons of the Crusades, to the scientific and medical advances of the Seventeenth Century. Chapter 18, "The Story of Smallpox and the Birth of Preventive Medicine," is the midpoint of the book and is followed by modern developments in preventive medicine.

The author, a resident of Mansfield and career public health officer, is well known to Ohio physicians. He is health commissioner of Mansfield and the Richland-Crawford County health district. Dr. Wain has worked extensively with the Ohio State Medical Association in the field of public health and preventive medicine, is active in the Ohio Rural Health Council and the Ohio Public Health Association.

Dr. Wain for many years conducted a column for *The Ohio State Medical Journal,* "The Story Behind the Word," in which he traced the origin of medical terms. Selections of these columns were later published in book form.

Science and Morality in Medicine: A Survey of Medical Educators, by Earl R. Babbie, *University of California Press,* 2223 Fulton Street, Berkley, Calif., 94720 ($7.50). With a Foreword by Otto E. Guttentag, M.D., this book reports a 1965-1966 national survey of medical school faculty members in the clinical departments of medicine and pediatrics.

The following excerpt from the Introduction to Part II perhaps may cue the reader as to the context of the book.

"Part two of this book advances the thesis that science is indeed undermining traditional morality. However, the phenomenon which we shall examine is much more general and more significant than might be imagined. Medical science is part of the general movement which is undermining a basic morality of American society as a whole. This movement is, of course, relevant to

Drug Ads OK

WASHINGTON—Drug advertisements in a medical journal are more reliable than some published reports by clinical investigators who draw "unwarranted conclusions."

This opinion was expressed by Arthur Kalett of New York, executive director of The Medical Letter—which carries no advertising.

"Readers of advertising have the protection of the FDA," he told a Drug Information Association symposium. "The FDA stands between the reader and the drug manufacturer.

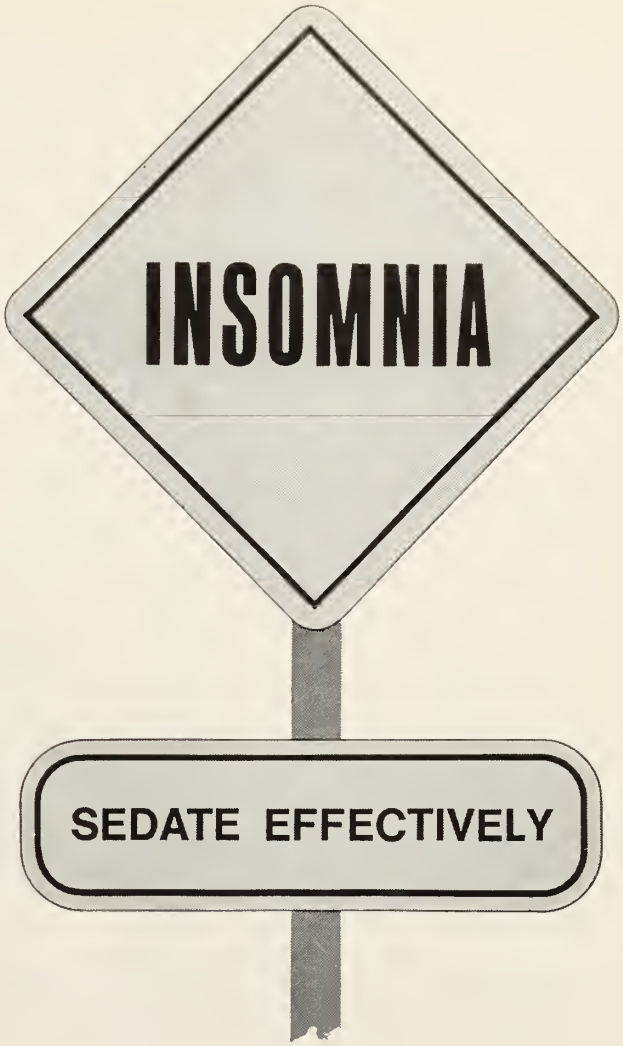
"The reader of a clinical report has only the editor standing between him and the conclusions of the authors."

Speaking on a panel of editors, Mr. Kalett recommended that authors of drug studies who submit reports of their work for publication should be investigated by the journal editor concerned if their reputations are not established.—*U. S. Medicine*, February 1, 1970.

medical morality, but it is not limited to medicine alone.

"In brief overview, the thesis to be advanced is the following. In the past, American society, including American medicine, has been informed by a morality of individual responsibility. Each individual has been held accountable for his own actions and for his success or failure in life. This individualistic morality, in turn, has been based on a belief in man's ultimate freedom. It has been believed that each person possessed the ultimate freedom for shaping his own destiny. Both the individualistic morality and the image of man as a free-will agent have had their roots in Christian religiosity and political conservatism.

"The scientific perspective, however, suggests a radically different image of man: as being largely determined by environmental and biological forces over which he has little or no control. This deterministic image of man is virtually a requirement of Western science. As a result, scientific perspectives conflict with the perspectives of Christian religiosity and political conservatism. Moreover, the decline of the latter perspectives has coincided with the growth of science. Ultimately, we are witnessing a decline in the traditional, individualistic morality and its replacement by a more deterministic social morality. This latter development has implications for medical morality and for all of American society."



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Following are names of new members of the Ohio State Medical Association certified to the headquarters office during May. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CLERMONT
William B. Selnick, Loveland

CUYAHOGA
Silvio Aladjem, Cleveland
Renate Hare, Cleveland
Gary I. Katz, Cleveland

FRANKLIN
Edmund D. Lowney, Columbus
Robert C. Pfeiler, Worthington

JEFFERSON
George M. Kosko, Steubenville

LUCAS
Robert T. Tidrick, Toledo

MAHONING
Jacques Politi, Youngstown

MARION
Harold Y. Allen, Marion

MUSKINGUM
Sidney Girsh, Zanesville

SUMMIT
Samir E. Kadi, Akron

Denver Cancer Conference Scheduled

The historic Brown Palace Hotel in Denver, Colorado, will be the site of the 24th Annual Rocky Mountain Cancer Conference. The Conference, to take place on July 17 and 18, 1970, is expected to attract over 400 physicians from all over the country.

Details can be obtained by writing to the Rocky Mountain Cancer Conference, 1764 Gilpin Street, Denver, Colorado 82018.

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

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hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

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GP Scientific Assembly

Columbus, August 4-6

THE ANNUAL SCIENTIFIC ASSEMBLY of the Ohio Academy of General Practice will be held at the Sheraton-Columbus Motor Hotel, with the scientific features of the program scheduled on Tuesday-Thursday, August 4-6.

The Theme is "Progress for You—Something Old, Something New." The program is acceptable by the American Academy of General Practice for 12 prescribed hours. Exhibits will be featured at the meeting.

The House of Delegates will meet on Monday, August 3, beginning at 4:00 p.m., and again on Tuesday morning.

The program has been announced as follows:

Tuesday Afternoon, August 4

Welcome Addresses

Comprehensive Review of Brain Dysfunction

Introduction of the Subject—Joseph G. Peil, M.D., Middletown

Diagnosis and Treatment of the Badly Brain Damaged Child—Rosalie Wilkinson, M.D., Philadelphia

Diagnosis and Treatment of Learning Disabilities—Evan Thomas, M.D., Philadelphia

Questions and Answers with a Panel of the Foregoing Speakers

Tuesday Evening

Social Hour and Banquet

Wednesday Morning, August 5

Current Diagnostic and Therapeutic Approaches to Peripheral Arterial Occlusive Disease—Film by R. E. Fremont, M.D.

Office Management of Foot Problems—Management of Infant Foot Disorders—Dr. J. V. Ganley, Podiatrist, Norristown, Pa.

Questions and Answers

Early Recognition of Rheumatic Disorders of the Younger Years—Rodney J. McKenzie, M.D., Cincinnati

Question and Answer Session

Wednesday Afternoon

Office Prevention and Control of Atherosclerosis

Role of Exercise,—Who, What, Where?—Herman K. Hellerstein, M.D., Cleveland

Questions and Answers

A Horrible Menu in an Affluent Society—Frederick A. Kruger, M.D., Columbus

Question and Answer Session

Wednesday Evening

Marion Laboratories Party

Thursday Morning, August 6

Recent Advances in Diagnosis and Treatment of Angina Pectoris—Film by Richard Gorlin, M.D.

Multiple Office Procedures

Hearing Conservation in Industry—Marion T. Summar, M.D., Virginia, Minn.

Vertigo and Dizziness—Claude P. Hobeika, M.D., Cincinnati

What's New in Antibiotics—Samuel Saslaw, M.D., Columbus

What's New in Immunizations—Henry G. Cramblett, M.D., Columbus

Question and Answer Session

Thursday Afternoon

Special Session Covering Drugs and Narcotics
Registration Fee $10—Acceptable for three AAGP Credit Hours

Don't Blow Your Mind

The Role of the State Investigative Agency for Narcotics and Dangerous Drug Control—Albert D. Cook, Chief, Division of Narcotics and Dangerous Drugs

Drug Abuse and Drug Dependence—Rupert Salisbury, OSU College of Pharmacy; Psychiatrist, Louis A. Cancellaro, M.D., and Sociologist, John O'Donnell, Ph.D., both of the Mental Health Clinical Research Center, Lexington, Ky.

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Controindicotions: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Worning: Althaugh generally safer than the amphetamines, use with great cautian in patients with severe hypertension or severe cardiavascular diseose. Do not use during first trimester of pregnancy unless potential benefits outweigh patential risks.

Adverse Reoctions: Rarely severe enough to require discantinuatian af therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic af sympathamimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiavascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenamena reported include such conditions as rash, urticaria, ecchymasis, and erythema. Gastraintestinal effects such as diarrhea, constipation, nausea, vamiting, and abdaminal discomfort have been reported. Specific reports an the hematapaietic system include two each of bone marrow depression, agranulocytasis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mauth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libida, dysuria, and polyuria.

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Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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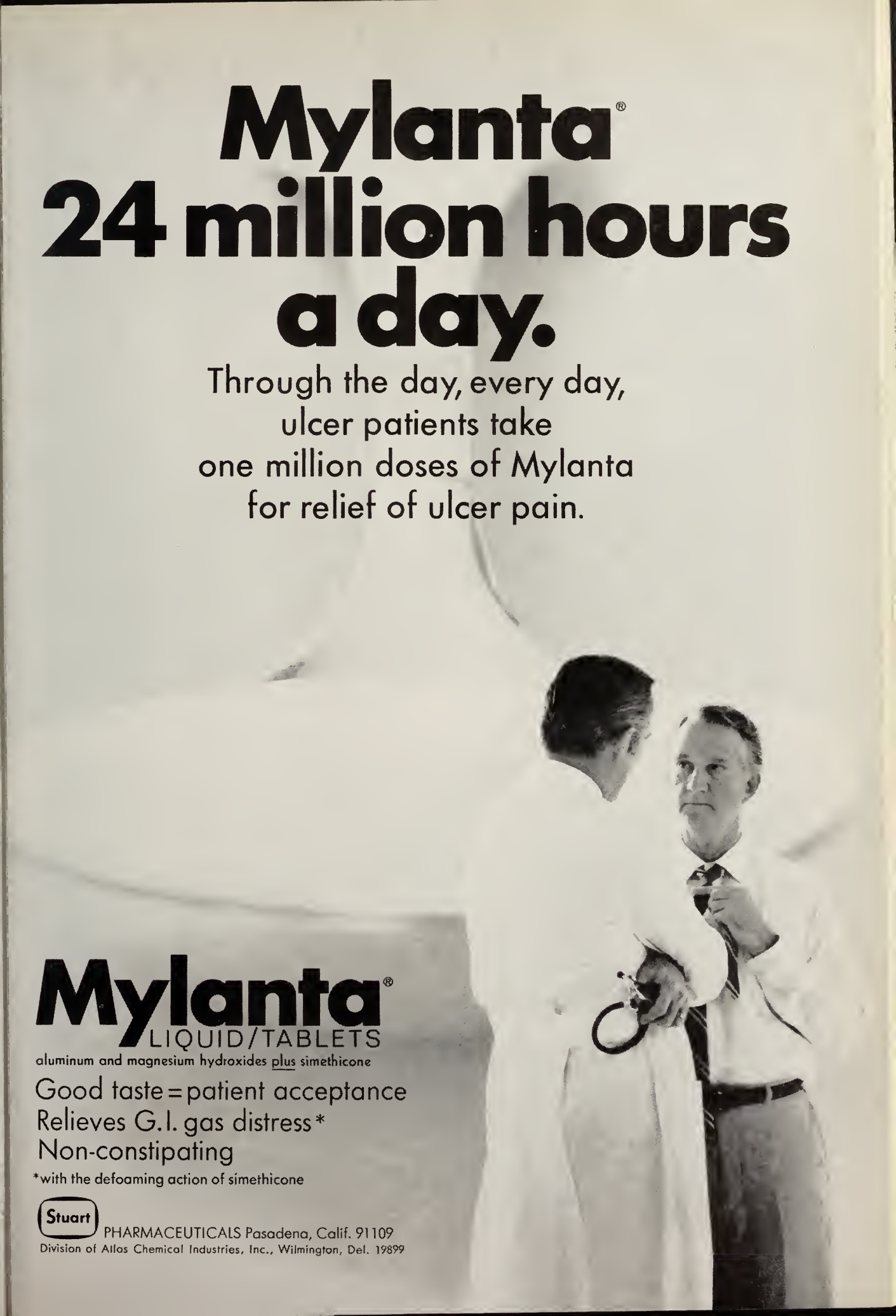
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Clinical & Scientific Features







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Symposium on Alcoholism

THIS LITERARY SYMPOSIUM is assembled for the physician and the medical student. It is fervently hoped that a better understanding of the illness alcoholism will result and that a change in response to the patient will follow.

The alcoholic needs genuine professional help. In describing a syndrome with social and economic ramifications, and about which there was much moralizing, Osler said of syphilis: "to know" this illness "is to know medicine." Nearly one century later, can't we substitute the word *alcoholism* for the term *syphilis?* There are striking parallels, particularly in the area of multiple system involvement.

Surely we have passed the stage of debating whether or not alcoholism is an illness. While we have indulged in semantic exercises and discussions as to what specialty the problem belongs, it has reached pandemic proportions. Alcoholism has become a major public issue and is the pressing concern of a community and its physicians.

History will record the impact of alcohol on our lives and on our civilization. Future medical chroniclers will likewise judge our attitudes and responses to the many challenges that alcohol abuse presents.

In this issue of *The Journal,* we are publishing articles 1 through 5. The symposium will be completed with articles 6 through 11 in the issue for August, 1970.

The Guest Editor would like to acknowledge the extensive support received in preparing these issues from *The Ohio State Medical Journal* staff and from my secretary, Madeline Freter. I also want to express my appreciation and profuse thanks to the authors for their contributions.

CHARLES N. HOYT, M.D.
Guest Editor

Preface

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ON BEHALF of all those who have helped to establish and advance this state's alcoholism program, I welcome the opportunity to acknowledge this important contribution by *The Ohio State Medical Journal.* This issue is especially timely in view of the current greatly increased concern about drugs generally, as well as the drug alcohol. Recognition of alcoholism or alcohol dependency as an illness by the medical profession is basic to our modern approach to alcohol problems in our society.

We are indebted to this profession for its pioneering contributions to the development of this modern concept of alcoholism. Among such pioneers was the Physician-Surgeon to the Colonial Army, Dr. Benjamin Rush, who challenged the then widely held opinion that spirituous liquors were beneficial. Earlier, in 1778, Dr. Thomas Trotter in a publication, *Essay, Medical, Philosophical, and Chemical, on Drunkenness,* in Edinburgh, declared that in medical language he considered chronic drunkenness a disease.

In the 19th century there was a considerable number of papers relative to the disease concept of alcoholism. During this period there were also several periodicals devoted to the subject of chronic "inebriety," emphasizing its disease aspects. In 1930, a committee of the Connecticut State Medical Society recommended the establishment of an inpatient facility for the medical care and treatment of individuals suffering from what came to be known as alcoholism.

However, it was not until very recent times that the acceptance of alcoholism as an illness became more firmly established. A little over 30 years ago, members of the Alcoholics Anonymous fellowship began to give personal testimony that chronic, abnormal drinkers were not hopeless drunkards. In 1956, the American Medical Association, by a resolution unanimously passed by its House of Delegates, urged the admission of acute or chronically ill alcoholics to general hospitals without prejudice. This resolution was reaffirmed in 1962.

Similar positions were subsequently taken by the American Hospital Association and the American Psychiatric Association. In March of this year, the American Hospital Association in cooperation with the Ohio Hospital Association conducted a conference in Columbus on "The Hospital Care of the Alcoholic." This was the first of such conferences to be held in this country under the initial leadership of the American Hospital Association.

Such a very brief review of the leadership executed by the medical profession and its influence upon the medical care institutions may suffice to indicate the indebtedness of the Ohio Department of Health and its Alcoholism Program. While prejudice continues to exist in some quarters with reference to the acceptance of alcoholics as a medical responsibility, the leadership of the medical profession and its related institutions is gradually reducing these attitudes to minimal proportions. Such influence is very much in harmony with the Health Department's community centered type of alcoholism program approach. In essence, such an approach recognizes that education for the prevention of alcoholism

as well as the rehabilitation of alcoholics should be fulfilled at the community level where the problems arise and the primary remedial services exist. Consequently, in 25 Ohio communities at this juncture the cooperative leadership of local medical personnel, their ancillary services, and medical institutions, is most respectfully sought by their local Council on Alcoholism and the administration of their community alcoholism program.

Again, therefore, all of us who are concerned about alcohol and alcohol problems in our society most earnestly welcome these particular editions of *The Ohio State Medical Journal.*

Outline:

1. The Alcoholism Problem. A Challenge to Medical Leadership by Martin D. Keller, M.D., Professor, Department of Preventive Medicine, The Ohio State University, and Franklin R. Banks, Ph.D., Professor, Department of Preventive Medicine, The Ohio State University.

2. Alcoholism. A Review and Overview of the Problem by Charles N. Hoyt, M.D., Clinical Instructor, Department of Preventive Medicine, The Ohio State University.

3. Is There a Biochemical Lesion in the Disease of Alcoholism? Edward B. Truitt, Jr., Ph.D., Senior Fellow (Pharmacology), Battelle Memorial Institute, Columbus.

4. D.D.T. — The Drinker's Dilemma and Treatment. A Psychiatrist's View by H. T. Goodman, Jr., M.D., Columbus.

5. The Outpatient Treatment of the Alcoholic by Richard E. Bibb, M.D., Assistant Professor of Psychiatry, University of Cincinnati College of Medicine; Associate Director, Central Psychiatric Clinic; and Medical Director, Alcoholism Clinic of Cincinnati.

6. Alcohol and Liver Disease by John Fisher, M.D., Fellow in Gastroenterology, and C. Joseph DeLor, M.D., Professor of Medicine, The Ohio State University College of Medicine.

7. (Limited) Usefulness of Electroencephalography in Alcoholism by Charles E. Henry, Ph.D., Department of Neurology, Cleveland Clinic.

8. Some Remarks on the Physician's Role in the Treatment of Alcoholism by Maurice Victor, M.D., Professor of Neurology, Case Western Reserve University School of Medicine.

9. Rosary Hall. An AA-Oriented Hospital Alcoholic Care Unit by E. Mascarenhas, M.D., Frank R. Hanrahan, M.D., and John J. Plucinsky, M.D., St. Vincent Charity Hospital, Cleveland.

10. Practical Experience with an Alcoholism Program in Industry by William W. Davis, M.D., Medical Director, North American Rockwell Corporation at Columbus.

11. Let's Take Another Look at Alcoholism by Lewis K. Reed, M.D., Youngstown.

The Alcoholism Problem
A Challenge to Medical Leadership

Martin D. Keller, M.D., and Franklin R. Banks, Ph.D.

THE World Health Organization defines alcoholism as a chronic behavioral disorder, manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that it interferes with the drinker's health or his social or economic functioning. If we choose to consider this a disease, we make its major focus medical. That is, it behooves the medical profession to take leadership in the prevention and management of alcoholism and in the rehabilitation of the alcoholic. This does not imply that the physician can do this single-handedly or that all of the factors associated with the control of this disease can be managed by the medical profession alone. It does put the medical profession in a position of leadership responsibility.

What is the extent of this problem? One approach to the estimation of the prevalence of alcoholism was proposed by Jellinek,[1] utilizing the reported mortality from cirrhosis of the liver. This method has been widely employed despite methodological criticism. The Jellinek Estimation Formula indicates that there are about 4,500,000 alcoholics in the United States, or approximately 4 percent of the adult population. This is a frightening figure that may be an overestimation, but the formula has been confirmed in a number of comparison studies.[2] It is also estimated that the ratio of male to female alcoholics is about six to one. Recent estimates made by the Alcoholism Unit of the Ohio Department of Health indicate a prevalence of about 290,000 in Ohio. This high prevalence and the serious physical and social consequences of this condition assign to alcoholism the position of a major public health problem in the United States, being outranked perhaps only by accidents, mental disease, heart disease, and cancer.

The epidemiology of alcoholism has also been approached through the study of this condition in specific institutional or industrial settings. Locke and Duvall[3] examined 3,339 persons admitted for the first time to public mental hospitals in Ohio, with the diagnosis of acute or chronic brain syndrome associated with alcohol intoxication and/or alcohol addiction. The admission rates were significantly higher among males, nonwhites, laborers and service workers, and individuals with lower educational achievement. The question remains as to whether the individuals admitted to public mental hospitals are predominantly those to whom other sources of care are less available. It is difficult to draw generalizable conclusions from these findings.

Trice[4] summed up the general findings of the study of alcoholism in industrial settings. There is apparently much variation in the prevalence of problem drinking in different industrial settings. However, the high-risk individual appears to be the male employee, between the ages of 35 and 50. There is significant decline in work efficiency and an increase in absenteeism as alcoholism develops.

The community survey is another approach to the epidemiology of alcoholism. Mulford and Miller[5] interviewed 1,185 persons, chosen by quota sampling, in Iowa. While 58 percent consumed alcoholic beverages, only 3 percent could be classified as alcoholics. In general, the high-risk individuals were urban males, Catholic, between the ages of 36 and 60 years, and having no more than an eighth grade education. Bailey and co-workers[6] conducted interviews in 4,387 households in the Washington Heights Health District in Manhattan. Their findings indicated the male, nonwhite, less educated individual was more susceptible to alcoholism. Nonwhite females had higher rates than white females. Lower rates were found among the Jewish population than among the other religious groups. Significantly higher rates were found among men who were widowed, divorced, or separated from their wives.

It is difficult to interpret the findings concerning variations in rates of alcoholism, for

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utilization in the design of a strategy for the control of this health problem. It certainly appears that sociocultural factors play an important role in the rate differentials. One approach to understanding these factors was proposed by Bales.[7] He suggested a number of ways in which culture and social organization may influence rates of alcoholism. The degree to which a culture or subculture operates to bring about acute needs for adjustment, particularly as it induces guilt, anxiety, and conflict, may play a role in the need for alcohol or some other agent to relieve tension. In addition, cultural attitudes regarding alcohol differ widely. Bales described four general attitudes:

1. Complete abstinence, usually put forth on religious grounds, not permitting the use of alcohol on any occasion.
2. Ritual attitude, in which the consumption of alcohol is part of a ritual act of communion with the divine.
3. Convivial attitude, in which drinking is a social act, enhancing social solidarity by reducing inhibitions and facilitating social ease and goodwill.
4. Utilitarian attitude, which is conducive to solitary, personal, self-interested consumption of alcohol.

Bales feels that these last two attitudes are most conducive to the development of alcoholism. Another factor associated with the differential rates of alcoholism might be the extent to which the culture provides alternative means of satisfaction and tension reduction. Occasionally, these alternative means are in themselves health problems, such as the use of various narcotic drugs.

In view of all these concepts, how may alcoholism be prevented and how may the condition be managed? One is always tempted to put forth educational programs as the key to primary prevention. However, there are few well-designed studies that indicate the value of specific educational approaches in reducing the incidence of alcoholism in a defined population. However, this need not inhibit the introduction of a clear presentation of the problems of alcoholism and the consequences of this health problem to children in school, as part of their general health education. Skillful presentation of this information, with alcohol being put in the position of a potential agent of disease, may help orient the children in a way that counteracts some of the social pressures that are conducive to the development of alcoholism.

General alteration of social attitudes and the conditions that lead to tension and the need for tension-reducing agents such as alcohol, require so vast a reorganization of the social fabric, that it is far beyond the realm of any one professional or educational group. There is no clear agreement on the manner in which such change can be made, or whether it would indeed be desirable. Consequently, there are few meaningful programs of primary prevention that have been broadly adopted.[8]

It appears that most of our strategy must lie in the area of secondary prevention. This is classically based upon the early detection of a health problem, and prompt attention to reverse, halt, or slow the progression of the condition. In this phase of intervention, the medical profession may have its greatest impact. The first step must be the clear acceptance of alcoholism as a disease. This acceptance will encourage the community to provide facilities for acute care and rehabilitation for alcoholics, according to their ability to pay. The social and economic losses incurred through alcoholism far outweigh any expense that may be involved in making such care available. It is only in such a medically-oriented setting, that the alcoholic would seek care and find the type of care that he is likely to accept.

Sooner or later, the courts will rule that alcoholism is not to be treated as a criminal offense. The medical profession and its allied professions must be ready to accept this challenge. It is a generally accepted principle, that the earlier the detection of a health problem, the greater are the chances of successfully managing the condition and restoring health. With the backlog of uncared-for alcoholics being built up in our communities, we have before us the entire spectrum of need for care, ranging from the beginning problem drinker to the severely brain-damaged chronic alcoholic who requires custodial care for the remainder of his life. With improvement in the personnel and facilities for the treatment of alcoholism, more of the early cases will be detected and successfully managed.

The physician has a centrol role in the early detection of problem drinking and alcoholism. Given a chance, the patient is more likely to discuss problems of this sort with his physician than with almost anyone else in the community. Perhaps the best approach is the inclusion of the subject of alcohol consumption, in an appropriate way, in the general medical history. This presupposes a willingness on the part of the physician to confront his patient with this type of question. The physician and the patient must overcome their prejudices and cultural blocks with regard to alcoholism.

The physician faces the difficult decision as to when drinking may be considered a health problem. However, there are many clues that could alert both the physician and the patient. A medical history that includes questions regarding problem drinking is exemplified by a small questionnaire distributed by Alcoholics Anonymous. This questionnaire, which is entitled "Who Me?", is based

on a format used at the Johns Hopkins University Hospital. It probes the nature of the drinking, the place and time of drinking, the effects of alcohol on the individual, including his ability to control himself. This questionnaire may be obtained from Alcoholics Anonymous and adapted by the physician to his own history form. Frequently, early in his drinking career, the alcoholic has a reputation for "holding his liquor." He rarely has a hangover but may begin to experience withdrawal symptoms, such as morning tremors or occasional memory blackouts. Despite such manifestations of illness, the patient may not be willing to admit that he has a problem, but he may be helped to do so by his physician. It is also important to obtain a history of alcoholism in the patient's family. Studies have indicated that this problem is familial and may have a genetic basis.

The concerned physician can assist in the early detection of alcoholism, reducing the physical and social impact of the problem in the particular case. It is sometimes said that alcoholics must "hit bottom," before they are willing to seek help. While this may be true in some cases, it is quite likely that early detection and prompt attention will raise "the bottom" and abbreviate the problem-drinking career.

The entire problem of alcoholism is an excellent model for community organization in the achievement of health goals. Alcoholics Anonymous presents a very special type of "consumer participation." In this case, individuals who experienced this problem organized themselves to give assistance to other individuals facing the same problem. It is clearly possible and highly desirable to develop a coalition between the patient, his physician, Alcoholics Anonymous, and other appropriate community agencies to cope effectively with this disease. There is a clear need for medical leadership in this matter. The physician stands in the position of spokesman for human health in our communities. A concern for alcoholism expressed by organized groups of physicians and the spokesmen for the medical profession would lend credence to the position that this is essentially a health problem rather than one of criminality and social deviation. While each physician should primarily attend the problems of his patients, it will take the organized voice of the medical profession to overcome our community prejudices and achieve control of this serious health problem.

References

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Alcoholism

A Review and Overview of the Problem

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For all the happiness mankind can gain
It is not in pleasure, but in rest from pain.
(John Dryden)

IN AN ERA when confusion, poor organization, a struggle for leadership, and creeping government control characterize the health scene, we find the syndrome alcoholism seeking universal acceptance and appropriate therapeutic attention. Such an erroneously labeled "self-inflicted" illness can hardly be expected to receive top sympathetic and financial priority when the needs of the poor, the health insurance controversy, the country's economic and the taxpayers' crises, and the Vietnam War remain the critical issues. That alcoholism finds itself included in legislation and health

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schemes at all is progress compared with the picture two decades ago.

No one can deny that the nation is experiencing major health problems. Bureaucratic guide lines and controls have to date compounded the dilemma and, regrettably, the physician is slowly abdicating his role as a health leader. Pseudo-professionals have entered the health field and are seizing upon apathy and confusion to foster revolutionary ideas. That alcoholism may be used by some of the social and health planners as a tool or an entering wedge for the disguised promotion of radical sociologic change is a distinct possibility.

The Problem

In spite of its being recognized as an illness by the American Medical, Psychiatric, and Hospital Associations, alcoholism remains an emotional issue, a controversial entity, a dirty word, a means of attracting federal dollars, but most important of all, a neglected public health problem of pandemic proportions. That we face the matter with ambivalence and hypocrisy needs no elaboration. We are a drinking nation and one that feels a little guilty about its imbibing. Is it any wonder that those who "can't hold their likker" and fall by the wayside are shunned? There are as many myths and misconceptions about alcoholism as there were about epilepsy a century ago. Yet these are perpetuated by a drinking society out of sheer ignorance and defense of its own drinking.

The illness concept has not gained favor because it has not been taught. Today we find a scene of shameful neglect by a country which, in some areas, has developed a sophisticated technology that has surpassed man's ability to control it. Along with other areas of inattention, alcoholism becomes a fertile field for the invasive "involvement" of the organized do-gooders. Thus the illness becomes a double challenge to the physician. He must educate himself and treat the problem, and he must get back in the field of community health where his leadership and expertise are needed.

The Magnitude of the Problem

For those who drink, alcohol creates difficulties (social, economic, health) for about 15 percent. Of these, half are alcoholic, half are problem drinkers. Of greater significance is the estimation that between the ages of 35 and 50 years, the most productive years of a man's life, one out of every seven American males develops a drinking problem. Amongst the more affluent, the ratio of male to female alcoholics is now felt to be 1:1. If just the patient himself or herself were affected, the situation would not be as catastrophic. But it is calculated that for every person involved with alcohol excess, there are five other individuals caught up in the syndrome. The illness starts to take its toll early on the lives of the spouse and the children. The fellow worker feels the effects as does the employer and the neighbor, to say nothing of friends. If we choose to get dramatic about it, we wouldn't be too much in error if we implicated one fourth of the country's population in the ravages of alcohol abuse.

Other figures are equally telling, particularly in the area of treatment services. Accommodations for the care of the acutely ill alcoholic are woefully lacking across the country. Jails, workhouses, and "lock-ups" dry out more alcoholics than all other facilities combined. Tragically and inexcusably, in this universal incarceration process, alcoholics are dying daily in delerium tremens (DTs), which, untreated, carries with it a 20 percent mortality.

Of the nearly 300 state mental hospitals in the United States, about 25 percent of the census is alcoholic. Fifty percent of male first admissions are drinking problems. Yet only 10 percent of these state facilities give special attention to the alcoholic.

Although a touchy subject, it has been estimated that 25 percent of welfare recipients are alcoholic or have severe drinking problems. A recent informal survey of the records chosen at random of some 2000 Title XIX (Medicaid) Ohio applicants or recipients (Aid for the Disabled and Aid for Dependent Children-I) revealed a 21 percent incidence of diagnosed or strongly suspected alcoholism. With the tendency of caseworkers to protect their clients, a materially higher percentage seems likely.

With the death rate from causes related to alcohol showing an increase in almost 60 percent over the past 15 years, we find only about 10 percent of general hospitals without psychiatric services admitting alcoholics and only 6 percent treating chronic alcoholism. Yet we all know that most general hospitals "smuggle" in alcoholic patients under such quasi respectable cover diagnoses as "gastritis," "malnutrition," "acute brain syndrome," "pancreatitis," "hepatomegaly," "depressive reaction," "character disorder," and "schizophrenia, paranoid type." This subterfuge is employed to protect the patient and his insurance program, but it shields his drinking, perpetuates the illness, and supports the denial mechanism of the alcoholic, the biggest stumbling block to productive patient rapport.

The Illness Concept

The late E. M. Jellinek of Yale, a biostatistician, developed an interest in alcoholism back in the thirties and, along with Howard Haggard, M.D., founded the Yale School of Alcoholic Studies (now located at Rutgers University). He had more than superficial contact over a period of

years with several thousand alcoholics and formulated criteria for the diagnosis and a classification of alcoholism. These remain totally adequate and internationally accepted today and a review of the principles will help to clarify the illness theory. Appreciating these concepts, I think most physicians will come to recognize why many of us feel that alcoholism is an illness per se, and not necessarily a symptom of some other underlying condition.

Initially we start with a definition, and a medically oriented one is worded: Alcoholism is a chronic, progressive, relapsing disease complex, with probable inherited features, characterized by preoccupation with alcohol and loss of control over its compulsive consumption. Simplification helps to better understand the classification of drinking problems. For years two types of drinkers were acknowledged, those who could control their intake, and those who couldn't. Experts later described primary and secondary alcoholics, the former becoming recognized as the true alcoholic or the alcoholic addict, the secondary type defined as the reactive or the symptomatic or the problem or the non-addictive drinker. The separation of alcoholics into addictive and non-addictive types, appears to have definite clinical value.

Using the Greek alphabet in his typology, Jellinek spoke of four major categories of alcoholism: Alpha, Beta, Gamma, and Delta. The Alpha alcoholic, or the symptomatic or the problem or the non-addictive drinker, is using alcohol to make life more bearable. Alpha alcoholism is a purely psychological reliance upon alcohol to relieve psychic pain. The drinking is undisciplined in the sense that it contravenes such rules as society or the individual's peer group agree upon, but it does not lead to loss of control or inability to abstain. There may be considerable associated psychiatric illness. There may be interference with the harmony of the household, the family budget, and the employment record, but there are not any signs of a progressive process. This species cannot be regarded as an illness in and of itself.

Beta alcoholism is the type in which such medical complications as gastritis, cirrhosis, polyneuropathies, and other pathology may occur without physiological dependence on alcohol. The damage is not only physical, but there is impairment of economic functioning. The life span of the individual is shortened. Exogenous factors such as social, cultural, and vocational influences may predispose to this type drinking, which may be deviant by some standards but totally acceptable by others. The traditional example of the latter is the viticultural setting of France, where wine plays an important part in the life of the individual. We may be seeing the emergence of this species of alcoholism in this country associated with certain vocations, where the custom may be neurotic but where the patient shows little physical or psychological dependency. Beta alcoholism also cannot be regarded as an illness in itself, but both it and Alpha alcoholism may evolve into alcohol addiction.

The Illness

The Gamma and Delta species are those recognized as classical alcoholism. Both represent true physical addiction, addiction at the cellular level, and one might postulate that these types have a high degree of genetic biological determinacy for addiction to alcohol. Gamma alcoholism appears to be the predominating species in this country and it is this category that comprises about 75 percent of the A. A. community. Both Gamma and Delta alcoholism are illnesses in and of themselves; they are the "disease" as originally described by Jellinek.

Persons so afflicted may have varying degrees of psychological vulnerability at the onset of their drinking careers, but the important factor to appreciate is that the early history of a significant percentage of these alcoholics does not reveal immature, neurotic, or psychotic problems. These people drink for pleasure, many excessively, and over a period of years (5 to 15), the addictive process takes over. As Jellinek described, there occurs in the Gamma and Delta alcoholic an increasing tissue tolerance for and an adaptive cell metabolism to alcohol. Alcohol becomes incorporated in the metabolic cycles of the cells of the body. These cells behave as if they have become used to the substance, so that alcohol assumes the characteristics of a chemical constituent required by these cells. The organism is changed in such a way that it seems to get along better with alcohol (for a while) than without it. An artificial need for the drug has been created as a result of prolonged, excessive drinking.

As the Gamma and Delta alcoholics find themselves drinking more and more over a period of years to achieve the same pleasurable effect, they learn that alcohol relieves tension and anxiety and frustration. Alcohol is now used to handle emotional emergencies, and the addictive process is accelerated as the alcoholic conditions himself to drinking for pleasure and drinking to relieve pain—for alcohol still brings positive rewards. Then something happens! A critical milestone in the drinker's career is reached. Call it a point of no return, but it is probably when irreversible physiologic addiction sets in. Now the alcoholic's tolerance for the drug decreases; it requires progressively less alcohol to produce now an entirely different effect, an effect or personality change that is totally out of character for the patient. The spouse frequently refers to this phenomenon

as "He's a regular Jeckyll and Hyde now when he drinks; he never used to be that way." (This reaction is not to be confused with the acting out of the emotionally disturbed intoxicated individual.) The uncontrolled and inappropriate hostility, aggressiveness, and antisocial behavior encountered probably represents a toxic psychosis, but the ease with which it is precipitated would suggest some dramatic alteration in the pharmacologic action of alcohol on the brain. Alcohol, acetaldehyde, and the biogenic amines are discussed in another paper in this symposium.

Two other characteristics or symptoms appear in Gamma and Delta alcoholism indicative of physiologic dependency. The alcoholic begins to experience withdrawal symptoms when alcohol is leaving or has left the blood stream. In its mildest form, the withdrawal syndrome is manifested by tremulousness and "inward nervousness." This is suddenly first experienced by the heavy drinker for example on a Monday morning after a hard-drinking weekend. The "shakes" may be reflected in the handwriting or in the unsteady attempt to get the coffee cup to the mouth; or the patient may state that he feels so "nervous" that he is going to "fly apart." The drinker soon learns that the treatment of choice of first stage withdrawal is alcohol. The morning drink, sneaked at home or on the way to work, or the martinis or beer at lunch, soon handle his shakes, clear his head, quiet his churning stomach (after he has kept the first one down)—and it is as if he has made a great discovery. But he necessarily guards it secretly and soon finds himself drinking surreptitiously.

It is not within the province of this paper to discuss the other components of the abstinence syndrome, but I will mention them in the order of their severity because they represent one of the more serious of the medical problems of the alcoholic. Aside from morning tremulousness and nausea, we next recognize hallucinations, both visual and auditory, then seizures or alcoholic epilepsy or (recently coined) "alkalepsy." Finally comes delerium tremens (DTs), the most dramatic and grave of the acute complications the alcoholic experiences. Whereas the patient can control his shakes and frequently the hallucinations by re-establishing the blood alcohol level, DTs is a medical emergency requiring the attention of trained personnel in a hospital setting.

The fourth characteristic that identifies the alcohol addict is loss of control. In the instance of the Gamma alcoholic, he is unable to control his intake once he starts drinking; he doesn't set out to get drunk, but he invariably winds up that way. The Delta alcoholic on the other hand may be able to partially control his intake at any one period of time, but he is unable to abstain on a day-to-day basis without the manifestation of withdrawal. Thus undisciplined use of alcohol characterizes the illness alcoholism, but if we recognize the physical dependency involved, we more readily respect the severity of the problem.

To recapitulate, and focusing on the Gamma alcoholic, the predominating species in the United States, it isn't just a simple matter of taking a drink to calm the addict's nerves. The alcoholic has become preoccupied with drinking; the hour of the next drink becomes a critical issue and both his conscious and subconscious are planning his alcohol schedule. He soon unwittingly programs his day around beverage alcohol, for now he is drinking to live. Alcohol has indeed taken charge and completely controls and dominates his life. The craving for it and loss of control, the *sine qua non* of alcoholism, is not a simple psychologic process; it is a complicated biochemical and neurophysiologic mechanism.

The Psychology Involved

As psychologically oriented professionals, we physicians, by virtue of a constant authoritative contact with people, become cracker-barrel psychiatrists. We "psych out" and analyze patients, whether consciously or unconsciously, and some of us become indignant when our opinions are challenged. The field of alcoholism is full of such "experts." Add their ideas to the theories of especially trained alcohologists and psychiatrists, and you have as many etiologies of the illness as you have authors.

In discussing some of the psychology involved in alcoholism, it becomes apparent that we are talking about people in general with various personality traits and various potentials for neurotic and psychoneurotic illness. At the moment we are still forced to conclude that there exists a multiplicity of psychodynamic factors in alcoholism that are also present in both normal states and psychiatric illness. Situational, cultural, physical, and sociologic conditions may be decisive in the alcoholic's response to his psychodynamic structure. That through the ages alcohol in some form has been the most popular and readily procurable "tranquilizer" is a fact that cannot be minimized.

Most experts agree that there is none such as an alcoholic personality, but the addict or Gamma (and Delta) species has certain outstanding characteristics that are repeatedly encountered and that have come to typify the alcoholic. As R. Fox has noted: "A certain cluster of personality traits are found in most alcoholics during the active phase of the disease. These traits however may be as much a result of the years of addictive drinking, as they are the cause." The traits most frequently seen are described. There is a low threshold to frustration, conscious or subconscious rebellion and hostility, a tendency toward anti-

authoritative feelings, and dependency needs; egocentricity is glaring and a superficial, extractive, manipulative relationship with people is the rule. Repetitive acting out of conflicts is seen when drinking, and narcissism and exhibitionism are characteristic. As if compensating for a devaluated self-esteem, a feeling of (or longing for) omnipotence becomes the most persistent and annoying trait of all. A thread of this runs through every activity of the alcoholic's life and it becomes the principal barrier to recovery. As the first Three of the Twelve Steps of Alcoholics Anonymous imply, the alcoholic must admit and accept that his all-powerful self-image is "powerless" over something; that there is indeed Somebody bigger and better and wiser than he and that he must let this Somebody run his life if he expects to recover. The alcoholic's sense of omnipotence, of invulnerability is truly remarkable. Harry M. Tiebout, M.D. wrote: "The patients create the impression that the disaster, however threatening, cannot affect them. They are physically untouched by danger. While consciously troubled, they have a serene, unconscious belief in their own survival; they just cannot be licked."

The alcoholic is quite sensitive and may exhibit extreme mood swings. Somatic preoccupation and hypochondriasis are sometimes seen. Many patients show evidence of psychosexual immaturity. Indeed, it is immaturity, a regression to the childlike state, that characterizes the drinking personality of the patient. It cannot be stressed too strongly, as referred to above, that what we have described here of the alcoholic, may in no way represent his personality before the addictive process took over. This is frequently borne out clinically and represents the problems encountered by the psychiatrically oriented therapist or counselor who has been taught that alcoholism is symptomatic of something else. These professionals forever look for the "something else," for the occult, while the patient continues on with his drinking career, his very personality precluding satisfactory communication with the therapist. It has been my experience and that of others in the field, that if we remove alcohol from the picture, that is treat first things first, the majority of the emotional problems and many of the obnoxious traits of many an alcoholic will take care of themselves.

As the disease process becomes arrested, we see other features appear that a number of recovering alcoholics share in common. These people tend to be meticulous and perfectionistic. They are self-doubting, yet stubborn in their convictions. They have an exaggerated sense of duty and achievement. They become harassed by responsibilities, an excess of which they may seek. They may be overinhibited, possessing a strict, perhaps surplus conscience which becomes a driving force. They are happiest when achieving, yet never totally satisfied with a job well done. Thus they may have unrealistic goals, and as many find it difficult to carry on work under pressure, frustration comes readily. There is a lack of a normal capacity for relaxation and as tensions mount, so do anxieties which are frequently poorly handled. There is a tendency toward impulsiveness, and this coupled with obsessive qualities, makes it mandatory that things be done right now—if not sooner.

The above profile would suggest that all alcoholics are compulsive people. This is only partially true. The new American Psychiatric Association nomenclature describes 12 personality variants. Quite obviously all types drink and a certain percentage of all types get into trouble with alcohol. However, the personality structure that seems to have the best prognosis, the one that is seen actively and happily involved in A.A., is the one whose compulsive features are outstanding. Schizoids and cyclothymes and antisocial and inadequate personalities become heavy drinkers, even addicts, but it is my clinical impression that there is a particular proneness for the obsessive-compulsive to readily become physiologically dependent on alcohol. This deserves further investigation.

Treatment

No one will deny that alcoholism costs more in suffering and money than any other illness. Yet as a nation our treatment approach can only be described as deplorable. Admittedly the etiology of the problem remains obscure and current technics inadequate. Yet in spite of significant breakthroughs in neurochemistry that may herald a new era in appreciating behavior and addiction mechanisms, treatment solutions will still lag. The reason can be summed up in one word—*attitude*. Society's reaction to the alcoholic remains largely hostile. This in part reflects the moralistic teaching of previous generations. But in a nation that simultaneously encourages drinking and punishes drunken behavior, it also reflects society's ambivalence and guilt about its own drinking. It is no wonder that the stigma is perpetuated as society continues to condone punishment of the alcoholic.

As a multifactorial illness, the treatment of alcoholism becomes multidisciplinary. By the time the alcoholic asks for help, he is physically, psychologically, vocationally, financially, socially, and spiritually bankrupt. The overwhelming challenge of attempting to put this shell of a person back together demands the united efforts of all the facilities a community can muster. That no one treatment (excluding A.A.) regimen is superior to another has been repeatedly demonstrated. Our present percentage recovery rate is alarmingly low and the incidence of recurrence frustratingly high.

Unfortunately, the majority of those patients treated for alcoholism today are disproportionately drawn from that segment of the alcoholic population that is most difficult to handle. Where the occasional program has been successful, we see the physician, the psychiatrist (or psychologist), the nurse, the clergyman, the attorney, the probation officer, Alcoholics Anonymous, and various government agencies working together in harmony. This is Utopian in concept, expensive in practice, and assumes a smoothly operating referral system. Yet it is not unrealistic. It does involve however a community's wholehearted support and careful planning.

This multidisciplinary rehabilitative effort embraces the philosophy that a progressive continuum of treatment is the most efficacious. A community's effort would see not only the acceptance of the alcoholic in a hospital setting but the development of clinics, day hospitals, halfway houses, recovery farms, and possibly rehabilitation or addiction centers. The personality structure of the alcoholic is not so radically different from that of other patients with different symptomatologies that any ill person requiring rehabilitation couldn't benefit from the same chain of treatment services.

The most critical issue, however, is how to reach the majority, where the physical and psychosocial impairment is not severe and where there is still workable motivation. Unfortunately, there is a decided tendency in the middle and upper classes to hide and protect their drinking fellow members who are in trouble with alcohol. This inclination is unconsciously supported by the physician, the family, and the employer. Not until the disease process is well under way, not until an individual's drinking behavior becomes threatening, does it become mandatory that the stricken member receive help. This constitutes the revealing of a problem that sometimes embarrasses the peer group who now find it necessary to remove the sick member from the scene. If and when he recovers, he never again quite qualifies for active reintegration in said group as a non-drinking member. Such is the impact of alcohol on our society.

Obviously, to reach the majority referred to above, we should look to the one individual who most frequently encounters the prodromata and early phases of alcoholism. This person is the physician who is in the unique position to diagnose and offer help when the prognosis is the most favorable. Sadly, however, the medical community has not escaped the harmful influence of prejudice. During the active days of the temperance movement, physicians joined the ranks of the avoiders in the Wet-Dry conflict; — and here the preponderance remain. There are bursts of microscopic change, but as a general rule, physicians' attitudes are negative. Not until alcoholism appears in the curriculum of medical schools across the country will we find appropriate response to alcoholics on the part of doctors. It is interesting; a case of systemic lupus erythematosus (SLE) will attract the curiosity and prime attention of interns and residents, yet a chronic alcoholic, with just as many systems involved and eligible for top priority on any medical service, is shunned. In incipient DTs, with liver, pancreas, myocardial, and central nervous system pathology, to say nothing of disturbed electrolytes and other chemical abnormalities, the alcoholic may wait interminably in emergency rooms and on waiting lists literally begging for help. Ambivalence, ignorance, bias, all have made him an outcast.

I am sure that the heart of the matter today of the hostility between physicians and hospital personnel and the alcoholic resides in the patient's extreme sensitivity to the attitudes and responses of others, and particularly to negative attitudes. By the time an alcoholic reaches the point of hospitalization, he has encountered the spectrum of moralizing, sermonizing, rejection, contempt, and disdain. He has been repeatedly told in a variety of ways that he is spineless and weak-willed, that he has "brought this on himself." He has been almost continuously reminded by angry and accusatory family, relatives, friends, employers, judges, and others important in his dependency relationships, of his problem. The alcoholic reacts with counter hostility in an effort to protect what little self-esteem remains in him. This is all the defense that is left, since he has long since become unable to defend his drinking. Is it any wonder that we have a potentially difficult, manipulating patient? But if we recognize that every alcoholic, whether he shows it or not, is really ashamed, remorseful, and self-condemnatory, then we can better understand his reactions to any form of antagonism. Thus physicians and hospital personnel in reacting to the alcoholic as if he were the stereotypic patient, behave in the very manner best designed to provoke the alcoholic to act like the stereotype, and the stereotype is thereby self-confirmed and reinforced.

A discussion of treatment is not complete without a comment on wives and families of the alcoholic. Alcoholism is a family illness with the spouse and the children and/or close relatives intimately involved in the disease process. We have but to scrutinize the divorce statistics and the histories of emotionally disturbed adolescents for confirmation. The abuse of alcohol as a causal factor is significantly high.

The wife of the alcoholic, frequently seen as an innocent victim, may be as neurotically ill as her husband. Although unaware of it, her reaction to his behavior may be making the situation worse. Some wives are insecure individuals who have chosen their mates to satisfy some unmet needs of

their own. In their frustration at the alcoholic's irresponsibility, they retaliate, either actively or passively, in a punitive fashion. This serves to render the husband more inadequate and anxious and the drinking pattern worsens. As Fox pointed out, sometimes the "effect (of the wife) on her children may be more destructive than that of their drinking father. If she is unable to love, this may be even more detrimental to her child's development than her husband's inability to remain sober." Alcoholics Anonymous learned along the way that the entire family of the alcoholic must be treated if the patient is to recover. Thus Al-Anon (for spouses) and Alateen (for the children), companion pieces of A.A., came into being.

A final, less conventional, word about treatment is timely. Many of us now are willing to concede that total abstinence as a goal has been overemphasized and is sometimes maintained to the detriment of total life function. This is anathema to the philosophy of A. A. which has indeed helped more persons than all other resources together. But A. A. reaches less than 10 percent of the alcoholic population, and not all patients can adjust to this way of life. For the remainder, as research in the area of neurochemistry becomes more fruitful, it is not premature to anticipate technics and controls (even a "pill") to enable certain types of alcoholics to drink normally. This is an area of investigation that is relatively unexplored and only the lack of additional knowledge about the biochemical lesions in alcoholism prevents application.

Several aspects of treatment appear in this symposium on alcoholism. Being personally acquainted with the facilities and technics employed, distinct essentials become apparent that account for the success of any program. Four principles appear to govern favorable outcome: (1) Successful rehabilitation demands the cooperation of the various disciplines involved in the patient's care; (2) Most patients must be in some form of treatment indefinitely; (3) The treatment approach must be tailored to the individual; and (4) The treatment philosophy of choice would appear to be ego support rather than ego dissection.

Conclusion

Whether or not the established physician of today will be able to adjust to the gradual emergence of a new health care system remains to be seen. Society and a bureaucratic governmental complex are demanding and effecting changes that will see a new philosophy of medical care and a new physician image. We of the "establishment," of the private sector, will have to make compromises and concessions and modify our thinking if we are to function effectively in a market that will find us competing with other health professionals differently trained. The challenge today is not how to stem the tide of the social revolution in medicine but how to adapt in order to maintain leadership.

Private practice is changing in that we are seeing an increasing number of emotional problems — in all age groups — and more psychophysiologic disturbances. Harassed and overworked as the practitioner is, he has forgotten, or doesn't take time to listen. Offices, clinics, and emergency rooms are filled with troubled people, and we are dictating rather than listening and establishing productive doctor-patient relationships. There are not enough psychiatrists to treat these people, and if there were, I question that this is what our emotionally sick society needs. *All* of us, no matter what the speciality, are going to have to recall that technic of the art of the practice of medicine. We must again become humanitarians and exhibit that empathy with which we are traditionally endowed. An attentive, intuitive ear, a sympathetic shoulder, emotional support, and sincere reassurance are effective therapies. Those physicians, who "do not have the time" to establish that kind of rapport, are not rendering total service to their patients.

The Seventies will find us drifting from the age of anxiety to the decade of depression. Man will increasingly look for ways to relieve his psychic pain. The incidence of drug abuse and alcoholism will continue to climb. Surely we have reached the stage in the evolution of alcoholism where the physician has to stop "protecting" his patient. We have supported the denial mechanism and dishonesty of alcoholics to the extent that our afflicted patients now are literally scared to reveal their problems to us and are seeking help wherever they can find it. We physicians must change our attitudes. All of us are going to have to get involved, for these people need help. And no one—and I don't care how many degrees in sociology, theology, and psychology he possesses—is better equipped to handle the alcoholic than the physician. But to procure comprehensive care, the doctor must be willing to become part of a multidisciplinary team. Although he may qualify for a leadership role, he must acknowledge the need for the services of other professionals and work cooperatively with them.

Through the eyes of the alcoholic, the physician will slowly gain a different perspective of what is transpiring in the world of the impoverished. He then can't help but be better prepared to face community health issues and the addiction problem that will soon overwhelm us.

Is There a Biochemical Lesion in the Disease of Alcoholism?

Edward B. Truitt, Jr., Ph.D.

AN ANSWER to the title question would be valuable to the alcoholic, the physician, and the layman. The alcoholic would like to know that all the causes of his disease are not purely psychic. More physicians would become convinced that alcoholism is a disease, and its therapy might become more rational and even successful. Finally, public attitude toward the alcoholic and his problems should improve when physical as well as mental causes for the disease are substantiated.

It is certainly overoptimistic to hope for a single, clearcut, and biochemically definable lesion which would explain why all of six million alcoholics are unable to control their drinking. Nevertheless, many theories of alcoholism have been based upon the possibility of biochemical, nutritional, and physiological deficiencies.[1] Several investigators have considered that alcoholism might be an inheritable disorder like phenylketonuria, alkaptonuria, homocystinuria, galactosemia, etc., where a missing enzyme causes an inborn error of metabolism.[2, 3] The predominence of alcoholism in children of alcoholic parents has prompted checks on its hereditary nature by correlations with genetic markers such as color blindness, taste thresholds, and blood groups. However, the familial tendency can be explained as easily by environmental as well as genetic factors.

Metabolic Bases

Mice and rats can inherit a tendency for the voluntary consumption of alcohol,[4, 5] and this has been associated with a higher activity of alcohol dehydrogenase in their livers.[6] In humans a unique isozyme of alcohol dehydrogenase (ADH) has been identified, which produces the fastest rate of alcohol oxidation among all the multiple forms of the enzyme.[7] However, the presence of the atypical enzyme has not been correlated with a faster rate of alcohol disappearance in the body or with alcoholism.[8]

A faster than normal alcohol metabolism rate has long been suspected for alcoholics but only recently has careful quantitative proof of this been available. Mendelson[9] induced a more rapid conversion of ^{14}C-ethanol to $^{14}CO_2$ by chronic drinking in alcoholics, but he claimed the difference did not preexist in alcoholics tested with a single dose.[10] A study by Iber and his associates,[12] measuring ethanol disappearance rate, and another by the author,[13] using this index as well as acetaldehyde levels, point to a faster ethanol oxidation in alcoholics and to higher levels of the metabolite. Iber's group also found that faster ethanol disappearance in alcoholics does not necessarily mean more rapid appearance of a radiolabel in CO_2, because they convert ^{14}C-acetate more slowly to $^{14}CO_2$ than nonalcoholics. This finding can explain the failure of Mendelson and his associates[11] to find accelerated formation of $^{14}CO_2$ from a single ^{14}C-ethanol dose in alcoholism.

Biochemical Consequences of Ethanol Metabolism

Faster ethanol metabolism by alcoholics is interesting as a partial explanation of their well-known tolerance, but it can also produce two important consequences; a decrease in the hepatic NAD*/$NADH_2$† ratio and higher levels of the metabolite, acetaldehyde. In Figure 1, it is shown on the left of the diagram that NAD reduction is coupled to both ethanol and acetaldehyde oxidation. A shift toward greater relative amounts of $NADH_2$ is a well documented result of ethanol oxidation.[17] The surplus of $(H)^+$ is reduced through many routes of $NADH_2$-coupled reactions including lactate and fatty acid production and by coupled carriers across the mitochondrial membrane to the electron transport chain eventually to 0_2 (Fig. 1).

The adverse consequences, which are claimed to be a result of the decreased NAD/$NADH_2$ ratio, have been described as a "biochemical lesion" from alcohol. One of these effects is the fatty liver, which has been attributed by Lieber to an increase in fatty acid synthesis, but this theory is disputed by others.[14-16] Hyperuricemia resulting from

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*NAD—nicotinamide adenine dinucleotide.

†$NADH_2$—reduced nicotinamide adenine dinucleotide.

lactate excess,[17] decreased gluconeogenesis,[18] and deficiency in hepatic oxidative metabolism[19] are other defects attributed to the $NAD/NADH_2$ imbalance.

The production of greater amounts of acetaldehyde may also produce certain consequences which could be termed a "biochemical lesion". Acetaldehyde is present in very small quantities (less than 1 mcg. per ml.). The amount is normally limited by the slower rate of formation by ADH compared to its disappearance via aldehyde dehydrogenase. However, acetaldehyde is 500 to 1,000 times more potent than ethanol and produces many actions not shared by ethanol.[20] These actions include a selective interference with pyruvate-stimulated oxidative phosphorylation, inactivation of coenzyme A, metabolic stimulation, release of catecholamines from adrenergic neurons, and a shift to a reductive pathway in serotonin and catecholamine metabolism. All of these effects when produced chronically by increased amounts of acetaldehyde in alcoholics could be deleterious. Particularly, the effects on catecholamines could produce emotional and behavioral changes. A peripheral effect of norepinephrine release, such as lipase activation causing fat mobilization, would contribute to the fatty liver.

The reductive change in biogenic amine metabolism is shown in Figure 2, modified from studies by Davis, et. al.[21-23] Further study of the shift in catecholamine metabolism in this laboratory has shown that it is not ethanol or the ethanol-induced shift in the $NAD/NADH_2$ ratio, but the competitive effect of acetaldehyde against the aldehyde metabolites of the biogenic amines that

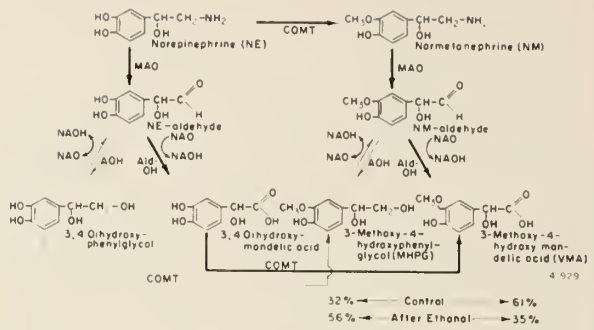


Fig. 2. Metabolic pathway for metabolism of norepinephrine. Enzymes: MAO = Monoamine Oxidase, COMT = Catechol O-Methyl Transferase, ADH = Alcohol Dehydrogenase, and Ald-DH = Aldehyde Dehydrogenase. (Modified from Davis, et al.[22])

forces the amines into a glycolated metabolite.[24]

An even more interesting change in biogenic amine metabolism has been shown for the effects of acetaldehyde on dopamine metabolism. In Figure 3, it is shown that a block of the normal aldehyde dehydrogenase pathway by acetaldehyde causes the condensation of dopamine with its aldehyde metabolite to form a tetrahydropapaveroline molecule, which could easily form a morphine-like compound by the same biochemical pathway as in the opium poppy.[25] This idea offers a fascinating

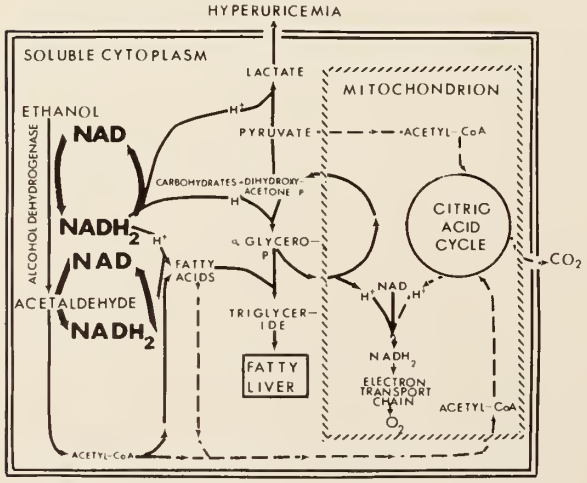


Fig. 1. Relationship of ethanol and acetaldehyde oxidation to H+ transfer and coupled metabolic reduction pathways in liver. (Modified from Lieber.[17])

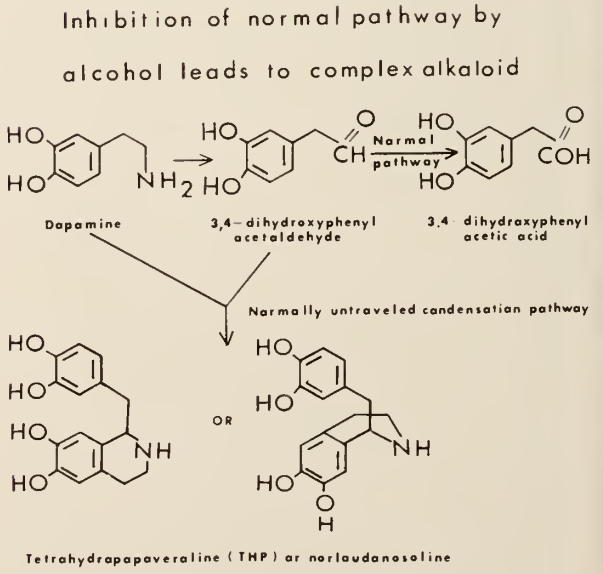


Fig. 3. Inhibition of dopamine oxidation by alcohol through acetaldehyde competition at aldehyde dehydrogenase step. (Modified from Davis and Walsh.[25])

prospect of welding together morphine and alcohol addiction.

Other Biochemical Bases

As a final biochemical disorder, hypomagnesemia has been suggested to be correlated with the neurologic manifestations of alcoholism during withdrawal.[26, 10] Magnesium is fundamentally important in the coupling of the electrolyte (Na^+ and K^+) movements across the neural membrane to ATPase. It is also a part of the micelle complexes of biogenic amines. Changes related to zinc deficiency have also been postulated as a symptomatic cause in alcoholism because of its role in the activity of ADH.[27]

Conclusion

At present there appears to be no primary candidate for a biochemical change to explain alcoholism as a disease. However, many aspects of alcohol action can be accounted for now in biochemical terms. The greatest likelihood exists that a disorder of alcohol metabolism or the consequences of accelerated alcohol metabolism may explain many aspects of the disease. Acetaldehyde, generated more rapidly from faster oxidation, may produce many biochemical changes and should be further considered as a factor in the pathogenesis of alcoholism.

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D.D.T. – The Drinker's Dilemma and Treatment

A Psychiatrist's View

H. T. Goodman, Jr., M.D.

ONE OF THE MOST perplexing puzzles facing a physician is that of the patient who presents a drinking problem. In many instances, the physician may find himself annoyed by the length of time required to treat the patient, as well as by the chronic features of the disease which, in themselves, imply treatment failure. However, the patient is likely to be more perplexed since he is involved in a social dilemma in which alcohol is acceptable, while the alcoholic individual is censured. Perhaps at this time a system of rationale which offers the physician a means of better understanding the alcoholic patient's plight — what he seeks, as well as what needs and why he needs it — can assist the physician either to treat his patient, if he feels sufficiently comfortable in doing so, or to refer the patient elsewhere.

The model proposed herein is designed to avoid confusing complexities, and is, therefore, somewhat general in nature. While it will not be applicable specifically to all those who represent drinking problems, it should be helpful to the physician by allowing him to view and understand his patient's plight more easily, thereby permitting more effective therapy.

The immediate dilemma presented by the patient will be related in some way to one or more personal decisions with which he feels himself confronted. Each personal decision, if reached, represents a commitment. The patient feels threatened by his great need to make the correct commitment; he experiences much anxiety which increases as he repeatedly contemplates the threat of being a failure should the outcome of his decision prove unfavorable. The alcoholic patient recognizes the fact that *no* decision represents the safest course to follow, but, at the same time, he views this course of inaction as representing another failure, which, in turn, produces an intolerable degree of anxiety from which he seeks relief through drinking.

The origin of the patient's problems will date back to his early years when he was learning to interact with people. It is not unusual for one of the parents to have been openly or subtly hostile, rejecting, and overly-aggressive, while the other parent may have been retiring and/or passive. It is not surprising that the patient will have superficially respected the "strong" parent while at the same time resenting him. He may also resent the passive parent for not being more assertive and protective. As a result of this family imbalance, one or both parents may have been drinkers. It would not be surprising if the patient appeared "quite mature" for his age during his secondary school years, seemingly able to handle his own problems as well as those of others. This early facility to handle problems during the growing years appears to have served as a means of inflating the patient's self-esteem at a period in his life when so many problems seem to be overwhelming. In reality, however, those same problems are quite simple when compared with those which confront one during the adult years; it is at this time that the individual becomes aware of the far-reaching consequences of decisions made in regard to himself and to others. It is perhaps the great need on the part of the patient to maintain this pseudo-inflated self-esteem of his growing years which permits one to understand more readily how much the patient really depends on others for emotional survival. It is important to remember that the patient *resents* being dependent on others on one hand, while he *needs* to be quite dependent on the other hand. He can express the resulting conflict quite clearly by "biting" the helping hand, whether it be that of his physician, spouse, or friend. In any event, this "biting," which may consist of threats, demands, or drinking, will be an expected part of the whole picture, possibly leading to rejection by one or more of those involved.

When the patient views himself as rejected, he becomes frightened, and he will likely respond in an overt or subtle hostile manner. The more the patient views himself as rejected by others, the more he sees himself as alone and not understood; he feels that he is isolated and that his situation is helpless. Increasing hostility toward those who he feels should care, with more indecision as to

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whether or not to express his thoughts and feelings because of the potentially dangerous repercussions from possible failure, finally produces a need to escape reality from the situation through drinking. Not infrequently, the patient can permit himself to make some decision after he has been drinking, if only to express his hostility more overtly, or to escape into a world of fantasy. However, any misbehavior which occurs during a drunken state, which the patient views as not really representing himself, may not be accepted by him.

The patient may repeatedly and sincerely express his wish to stop drinking, only to find that in time of anxiety he is plagued once again by an obsession to drink, and he finally does so compulsively. To stop drinking represents the most difficult personal decision with which the patient will be confronted. Alleviation of the symptom complex involved in drinking might be expected to require the substitution of another and more acceptable set of symptoms. One must remember that the substitution for the obsessive and compulsive elements probably will be gradual. Even after a period of not being obsessed with the craving for a drink, the patient may develop sufficient anxiety to experience his old obsession or craving once again, and he will perhaps return to the compulsive act of drinking, if only in a transient manner.

The treatment of the acute drinking episode is geared primarily toward relieving the immediate symptoms, and it is usually successful. When working with outpatients, the physician should use the various psychiatric medications quite judiciously since these drugs are not specific for alcoholism, and may result in excessive placidity, depressed mood, agitation, habituation and sometimes addiction, as well as present an opportunity for drug abuse and even death.

While it is imperative that the physician impress upon the patient the need to relinquish alcohol, he should never risk sacrificing the development and maintenance of rapport for the sake of what might well be considered a lecture or nagging, Likewise, "scare tactics" are to be avoided.

Through the use of leading and open-end questions, I have found that the truly motivated patient begins more rapidly to draw his own conclusions regarding himself and his difficulties, while the less motivated patient tends to express frustration over "not being given the answers" or "made well." Typical questions might include what the patient has been doing in regard to his situation, how he feels about his situation, what progress he has been making, and perhaps what it is that he really seeks through his drinking, as well as in his life.

The patient's family represents another vital aspect of his therapy. Either they will approach the physician for consultation, or the physician must approach them, realizing that an understanding of the family situation is indispensable to the understanding of his patient. While the family wishes sincerely to put an end to the situation, it will not be unusual to find that one or more members react in a way that only serves to promote continued drinking on the part of the patient. This encounter with the family provides an opportunity for each member to view any negative responses he might have to the problem, and to realize that such responses are understandable. This will help to increase their acceptance of the alcoholic individual's being ill, and will give the patient the proper impetus toward successful treatment.

Aversion therapy with disulfiram (Antabuse) has been one of the primary factors in the successful treatment of alcoholic patients. Disulfiram's biochemical interaction with alcohol usually produces a severe and often unforgettable illness. Probably it is either the threat of this illness or the severity of it that enhances the therapeutic success. Likewise, it is quite possible that the extreme fear and pain makes the patient's repentance more real to him, and forces him to decide whether or not to drink. If he decides to forego gratifying his obsession to drink, generally the obsession will decline in intensity after a matter of perhaps hours. This, of course, will signify that the patient has experienced success for that occasion. One must never forget that the patient may encounter a daily conflict in the process of deciding whether or not to take the Antabuse. Probably as an outgrowth of the factors associated with Antabuse therapy, the individual gradually realizes that he is capable of safely making decisions in regard to himself. If the patient has a great need to be self-righteous, compulsive, and self-centered, then the moral, ritualistic, and self-preserving aspects of establishing and maintaining disulfiram therapy may be used most constructively.

The group as a formal therapeutic element probably serves best by permitting the patient to become more conscious of the fact that there are others who are realistically aware of his plight, and therefore understand him. This would seem to provide a situation wherein he is able to view himself as less isolated.

Alcoholics Anonymous may best serve those who gain gratification particularly from helping others. The gratification would serve to enhance one's self-esteem to the degree that hope and meaning to life would be realized, and thereby permit personal decisions to be made without the presence of such extreme threat of failure.

Because of the patient's need for warm and dependent human relationships, the relative, friend, or physician who expresses a benevolent interest in him may, unknowingly, promote a kind

of situation which at times almost resembles that of a puppy toward its master. It is perhaps this relationship that results in the patient's apologizing to his benefactor for "letting him down" during a time of relapse.

The physician may be called upon to "do something" for a patient who drinks chronically, or who is severely intoxicated and still drinking, and who also refuses any medical help. Attempts to interrupt his supply of alcohol might result in extreme outbursts of anger and only accentuate his drinking. At the same time, it is important to be aware that in this country there are no clearly defined means of taking action in the patient's interest without his consent, unless he infringes on society to the degree that his condition is brought to the attention of the authorities.

While abstinence from alcohol may, in many instances, be a therapeutic goal, the patient's life may not be expected to be reorganized in such a way that it will be stress free. It is for this reason that the patient must be repeatedly reminded that, despite his idealistic wishes to the contrary, a relapse is possible and that he has some power to prevent it. Should this occur, he must likewise know that treatment can help him to recover again.

While patients with so-called "drinking problems" almost invariably resent the suggestion that they might require psychiatric help or hospitalization, there are, nevertheless, occasions when psychiatric therapy is indicated. Among the indications for psychiatric in-patient therapy are suicidal or homocidal thoughts or threats, and the complete inability to stop drinking without hospitalization. Indications for referrals for out-patient psychiatric considerations include a threat of an impending psychosis and instances in which the severe drinking is of short duration following a severe emotional upset, particularly in a mature personality. Finally, the family physician may refer his patient to a psychiatrist in order to obtain advice on how to treat his patient more effectively.

The alcoholic patient encounters one tremendous problem that the excessive drinker does not. The alcoholic is forced to contend with what appears to be addicition. This occurs after the individual has been drinking for at least several years and is characterized by a decreased tolerance to alcohol and profound withdrawal symptoms.

Clearly, no single discipline or combination of disciplines has been effective in a real sense in treating the more chronic phases of alcoholism. This may well be because of the obsessive-compulsive aspects of the patient's personality.

Generic and Trade Name of Drug
Disulfiram—Antabuse (Ayerst Laboratories)

The Outpatient Treatment of the Alcoholic

Richard E. Bibb, M.D.

THE ALCOHOLIC PATIENT and his doctor may struggle for many months or years before they are able to establish a meaningful relationship. Indeed, only a small minority of problem drinkers who seek help are able to progress to a mutually agreed upon termination of a successful treatment. Thus, in considering the outpatient treatment of these people, one must look beyond traditional views about psychotherapeutic treatment, especially the notion that it begins when a patient, motivated toward self-understanding, presents himself to a neutral, impassive therapist and proceeds in an orderly fashion (with the patient doing most of the work) to a natural termination at which point patient and therapist both agree that they have reached their destination.

Submitted April 6, 1970

The Problem

Before starting treatment one must have at least a frame of reference, if not a definitive diagnosis. Jellinek[1] has summarized over 40 different formulations about the nature of alcoholism, and Freud, Rado, Knight, Menninger, Glover, Brill, Sachs, and Jones are among the better known figures in the psychiatric world who have attempted to define the essence of the problem. A formulation of the psychodynamics of alcoholism which seems to lend itself especially well to the development of a sound strategy for treatment is that described by John Higgins.[2]

Higgins studied a series of 52 alcoholic patients at the Cincinnati Alcoholism Clinic and

found a wide variety of psychodynamic patterns in the early phases of alcoholism and a predominance of more primitive, infantile narcissistic elements in the severe later stages of alcoholism. These findings led him to propose that, contrary to popular conception, many alcoholics start drinking because of problems at a relatively mature level of personality development and that an autonomous pattern of behavior is then induced by the psychopharmacologic effect of alcohol, involving a regression to early, infantile modes of feeling and thinking. Higgins was saying, in effect, that there had been a tendency to mistake the autonomous pattern of behavior conditioned by the pleasure effect of alcohol for the personality of the individual patient, or at least for his peculiar predispositions.

Experience with a variety of psychoactive substances in recent years has led a number of workers to place increased importance on the question of what mental mechanisms are reinforced (conditioned) by particular drugs.[3] Thus, there seems to be a growing awareness of the need to distinguish between the problem behavior which follows drug use (and may continue for a long time to be influenced by it) and the forces which predispose the individual to excessive use of a mind-altering agent.

Phases of Treatment

What are the implications of this for treatment? There would certainly be nothing new in approaching the alcoholic with the view that definitive treatment will probably need to involve abstinence. Nor is there anything new about the idea that a multi-disciplinary approach may be necessary, involving vigorous attention to physical health, social work with the family, and contact with the clergy, employer, Alcoholics Anonymous, and/or other sources of help. What may be made clearer by the foregoing is that treatment of the alcoholic can be thought of as consisting of two phases, corresponding to two different aspects of the problem: one in which the patient learns that it is possible to overcome his sense of personal isolation and to transfer his dependence from an inanimate, pharmacologic agent to another human being (or a group of human beings); and a second in which he can resume the processes (interrupted by the drug-induced, regressive patterns of behavior) of personal growth and development.

The first of these phases requires the most from the helping person. Whoever works with the alcoholic in this phase—be he family doctor or psychoanalyst—must be sensitive, persuasive, energetic, and tactful, and must be able to respond actively—even heroically—to his patient's needs with a willingness to be tested and manipulated repeatedly. For example, the patient may cancel appointments without warning or come to the office intoxicated. Or he may demand to be seen on short notice or call in the middle of the night in a precarious state with urgent pleas for help. In such instances, one is more likely to be helpful if he responds actively, accepting the patient's demands, in contrast to what we tend to think of as appropriate posture in the management of the neurotic patient, or of the alcoholic in the second phase of treatment. Indeed, some psychoanalysts who have worked with alcoholics have said that the therapist may have to take such an active part in the patient's life in the first phase of treatment that when the patient has settled down and is ready for a working, trusting, therapeutic alliance, it may be necessary to transfer him to another therapist with whom he can work in a more conventional, detached, "as-if" relationship. In the second phase, the patient is able to take much more responsibility for helping himself, and he may or may not need the services of a professional.

Basic Mode and Strategy of Treatment (with Particular Reference to the Alcoholism Clinic of Cincinnati)

The most frequently used mode of treatment is the one-to-one psychotherapeutic interview which may vary in duration from 10 to 50 minutes and in frequency from several times a week to once every several weeks. Responding in a flexible way to the patient's emotional and reality needs is more important in the beginning of treatment than is attempting to teach the patient how to follow a prescribed model for patient behavior. It is obvious that there is a limit to what the therapist can do, but whether or not the therapy gets moving may very well depend on his willingness and ability to meet the patient more than half way at times. When he has reached the limits of his capacities (and this may happen many times in the first phase of treatment) the helping person must be able to make this fact clear to the patient in a way that continues to acknowledge his awareness and acceptance of the patient's emotional and intellectual vantage points. As the patient begins to show signs of ability to accept these limitations in his therapist, the process of learning how to use psychotherapy begins, and a more or less consistent progression toward a steady psychotherapeutic interaction can take place.

Other Modes

Medications, including Antabuse, may be of considerable value in getting started, depending primarily on the patient's (and, perhaps to a lesser extent, the doctor's) attitude toward these measures. In general, major tranquilizers and

tricyclic antidepressants may be somewhat more useful than minor tranquilizers or sedatives.

There is little doubt that the married alcoholic tends to respond better to out-patient treatment than does the unmarried alcoholic. It is likewise reasonably clear that the alcoholic whose spouse is also getting help has a much better chance of making good use of treatment than does the alcoholic whose spouse is uninterested or unable to participate in the exploration and management of the drinking problem. Casework therapy for the spouses of alcoholics, either on an individual basis or in close collaboration with the patient's therapist, or with conjoint interviews — regularly or intermittently during the treatment—has long been an essential aspect of our Clinic's program. In addition to helping the psychiatrist gain a better assessment of the setting in which the patient presents himself and providing additional support for the family, the caseworker may be able to work with the spouse to clarify her complementary role in the drinking problem.

Group therapy is considered by many to be superior to individual therapy in the treatment of alcoholics.[4] For the last 15 years or so a variety of types of group therapy has been applied in our Clinic. These range from groups consisting of homogeneous collections of patients with which the therapist or therapists are actively empathic and supportive in the group interaction, using a minimum of interpretation or confrontation, to a more analytic, heterogeneous type of group in which the therapists confine themselves to observations about the dynamics of group interaction and interpretation of psychopathologic behavior. A number of wives' groups have been quite successful, as have a number of married couples' groups. An open-ended group in which the therapist uses an approach which alternates between informal counseling in a group setting and a classroom approach is proving to be quite useful for socially and intellectually limited patients.

A number of therapists have found working with the alcoholic and his spouse together to be useful in certain instances. This is perhaps especially true when the marriage relationship has a reasonably good basis to start with. In such cases the therapist often has the impression that the married couple together has more strength to bring to bear on the problems than either one or both separately. However, when the marriage relationship is extremely labile, punctuated by outbursts of uncontrolled feeling and by attacks and counterattacks during the session, it is often useful to continue seeing both members of the couple but to see them in tandem rather than together. This device sometimes provides just the proper amount of emotional distance from crucial problems, permitting each member to work separately on the problems with a greater degree of objectively while they are both, in a very real sense, still working together. Perhaps most often conjoint or tandem sessions are used at one or more periods during the on-going treatment of the primary patient, for the purpose of clarifying particular issues at a time when the primary patient is ready to deal with them.

Certainly not to be overlooked when active intervention and environmental manipulation seem called for, and especially at the beginning of treatment, is the usefulness of a home visit by a doctor, caseworker, or visiting nurse. Such a visit can often help patient and family reestablish enough of an equilibrium to make out-patient treatment possible. Perhaps equally as important, it can provide firsthand information of a sort not available otherwise, and it can be useful as a means of establishing rapport which can become a basis for effective therapy. A word of caution: the visit must be in response to an expressed need, lest it be taken as an invasion of privacy which the patient or the family cannot tolerate.

Probation

More than 12 years of experience, two follow-up studies,[4] and a survey of therapists and records[6] point toward some interesting conclusions about the treatment of alcoholic patients as a contingency of probation in our Clinic. Perhaps most evident is the importance of the activity of the probation officer (or employer, union steward, etc.). One study in our setting showed that, given a loosely organized probation arrangement, 30 percent of the probationers referred to the Clinic in one year did not apply, while over half of those who did apply failed to follow through with their treatment for the duration of their probation.[5]

The usual reason for the breakdown of the referral system was that probation officers tended to depend on therapists to take the initiative for reporting on the patient's attendance and progress in treatment. This put the doctor in a dual role (of policeman and healer) which few, if any, could handle effectively. Thus the probation work (of policing the terms of the probation) was not performed, and most of the probation-referred patients did not follow through with treatment. The solution we have found for this problem is to permit a probation officer to work in the Clinic, where he can see all probationers after they have seen their therapists. In this way, the doctor is free to offer himself as a nonjudgmental, helping person who is relatively independent of the court and who can be trusted in a way that most patients cannot trust professionals whom they see as agents of the court, such as, for example, in a municipal court psychiatric clinic setting. Patients treated

under these circumstances seem to do as well as patients who come voluntarily.

Another important consideration in this kind of work is the experience of the therapist. A survey[6] undertaken in our Clinic a few years ago turned up the fact that, while inexperienced therapists tended to prefer work with voluntary patients over that with probation-referred patients, experienced therapists showed no preference for one or the other. The same study also demonstrated that 76 percent of the probation-referred patients were employed at the time of the study, while only 28 percent of the voluntary patients had jobs. One of the reasons why the inexperienced therapists seemed to prefer voluntary patients was that the latter openly expressed the need for help while the probation-referred patients often presented in an openly hostile manner initially, and not infrequently maintained this attitude toward treatment, although cooperating with it and proceeding toward a better adjustment. Thus, more experienced therapists seemed to have learned how to master their reactions to the hostility of the probation-referred patients and to work as well with them as with voluntary patients, while less experienced therapists seemed to prefer working with patients who openly professed their dependency even though the latter had a poorer work record, and usually, therefore, a poorer prognosis.

Summary

Traditional models for outpatient psychiatric treatment have not been satisfactory for work with alcoholic patients. A useful way of formulating the problem of alcoholism, which leads to a logical strategy for its treatment, is to distinguish between the autonomous, alcohol-induced behavior and the pre-alcohol personality of the individual. Only after the alcohol-induced sense of isolation and mistrust has been dealt with can a more conventional treatment begin.

The usual mode of treatment is one-to-one interview therapy, but this varies considerably in duration and frequency of sessions and in what adjunctive measures are applied. Medications, casework consultation, group therapy, conjoint or tandem therapy, and home visits are some of the many other treatment modalities which are used in conjunction with or as alternatives to the basic mode.

Outpatient treatment as a contingency of probation seems to yield results comparable to those produced by work with voluntary patients, if someone other than the therapist polices the terms of the probation. Beginning therapists tend to prefer to work with voluntary patients rather than probation-referred patients, but more experienced therapists claim to have no such preference, according to a survey in our Clinic.

Generic and Trade Name of Drug
Disulfiram—Antabuse (Ayerst Laboratories)

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(Symposium to be Concluded Next Month)

Newer Concepts of the Evaluation of Cardiac Function

William W. Parmley, M.D., and Edmund H. Sonnenblick, M.D.*

IN DEALING with the diseased heart, the clinician must make two important judgments. First, the underlying cause of the disease and associated anatomic defects must be determined, and second, the functional consequences of the lesion must be assessed. Although this latter judgment can often be made by a careful history and physical examination, or by imposing a stress such as mild exercise, it is often necessary to make more precise physiologic measurements of cardiac functions, which are best obtained during diagnostic cardiac catheterization. This article will briefly discuss some aspects of the cardiac evaluation obtained during catheterization, which deal both with the function of the heart as a pump and with the contractile properties of the heart muscle itself. In particular, it is necessary to evaluate to what extent an anatomically correctable defect is causing abnormal loading and "pump" failure and to what degree a depression of cardiac muscle functions itself has occurred.

The primary function of the heart is to maintain an adequate cardiac output appropriate to the changing energy requirements of the body. The cardiac output, which is determined by peripheral metabolic needs and return of venous blood, is the product of heart rate and stroke volume. The stroke volume of the ventricle, in turn, is influenced by three factors: (1) the preload or end-diastolic volume, (2) the afterload or pressure level which must be reached in order to eject blood into the aorta, and (3) the contractile state or "vigor of contraction" of the heart muscle.

1. The stroke volume of the heart is adjusted *beat to beat* by changes in preload or end-diastolic volume. Thus as the filling pressure and diastolic volume of the ventricle are augmented, the stroke volume increases, while the fraction of blood ejected by the ventricle remains relatively constant. This increase in stroke volume resulting from increments in end-diastolic volume is known as Starling's law of the heart and is a primary mechanism whereby cardiac output is altered on a beat-to-beat basis.

2. The second factor which influences stroke volume is the afterload. For example, from the same end-diastolic volume, a marked increase in aortic pressure will reduce stroke volume, while a decrease in aortic pressure will increase stroke volume. The reduction in stroke volume in a given beat due to an increased afterload, leaves blood behind in the ventricle so that subsequent end-diastolic volumes will be larger. With this increase in end-diastolic volume, the stroke volume will go up and output will be restored.

3. The third factor which influences stroke volume is a change in the contractile state of the heart muscle. The contractile state, or contractility of the heart, reflects the vigor of contraction and is characterized by the speed and extent of contraction. Normally the contractility of the heart is increased by norepinephrine which is released reflexly from sympathetic nerve endings in the heart or from the adrenal glands and

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is carried by the blood stream to the heart. The increase in the extent of muscle shortening (which accompanies an increase in contractility) is manifest by an increase in stroke volume at the same end-diastolic volume. Thus the fraction of blood ejected from the ventricle during each systole is augmented by an increase in the contractile state of the heart muscle.

In disease states, pump performance and muscle function may not be deranged simultaneously. Thus, in severe aortic stenosis, the imposed afterload may be of such magnitude that pump performance is impaired despite relatively normal muscle function. Similarly, in the presence of massive intracardiac or peripheral arteriovenous shunting of blood and markedly elevated cardiac outputs, congestive failure with massive fluid accumulation may ensue, although underlying myocardial function may be normal. *It is essential to distinguish failure due to abnormal loading of the heart from that resulting from depression of muscle function per se.*

The function of the heart muscle itself may best be analyzed in terms of the relationship between force development in the wall of the heart and the velocity of muscle shortening. This "force-velocity" relation is the most fundamental mechanical relationship of heart muscle and can be calculated from pressure and volume measurements obtained during catheterization. Although this cannot be routinely measured at present, current experimental studies suggest that it may become an integral part of future diagnostic catheterization studies. The value of this approach is that it provides a more precise measurement of muscle function aside from overall pump function of the heart, which may be influenced by valvular defects or abnormal shunting.

Although a consideration of the above factors allows one to describe cardiac function as a whole, it has recently become clear that localized areas of heart muscle have altered function, particularly in patients with coronary artery disease. With cine-ventriculograms obtained by the injection of radiopaque dye into the left ventricle, regional abnormalities of contraction may be recognized. These include areas of the heart wall which do not move at all (akinesia), areas which contract poorly (hypokinesia), and areas which expand rather than contract (dyskinesia). In addition, it is also clear that asynchrony of contraction of the entire heart may also influence cardiac function adversely.

Recent studies have also demonstrated that resting measurements of pump function during cardiac catheterization may be essentially normal in the face of considerable disease of the myocardium. Thus it becomes important to elicit abnormal function by stressing the heart. This is commonly done by having the patient perform supine bicycle exercise, by the intravenous administration of a catecholamine such as Isuprel, or by increasing the heart rate with electrical pacing. Furthermore, abnormal function may also be elicited by increasing the afterload with angiotensin, which increases arterial pressure but does not appreciably affect the contractile state of the heart itself. In patients with coronary artery disease, stress tests of the heart have been particularly useful in eliciting regional metabolic abnormalities (lactate production) as an indicator of regional hypoxia unassociated with angina pectoris. Such functional abnormalities have correlated well with the anatomic demonstration by coronary arteriography of occlusion or stenosis of a major vessel to that area of myocardium. The value of measurements made during stress testing of the heart, therefore, is that abnormalities may be induced, which are indicative of limited cardiac reserve even though the function of the heart as a pump may appear normal at rest.

In *summary,* therefore, the pump function of the heart can be measured in terms of filling pressure (end-diastolic volume) and stroke volume, while contraction properties of the heart muscle itself are measured by the "force-velocity" relation of the muscle. Furthermore, regional contraction abnormalities can be evaluated by the use of cine studies of the contracting left ventricle. A combination of the above studies can provide valuable information to the practitioner, which is of considerable benefit in both the diagnosis and treatment of clinical heart disease.

Generic and Trade Name of Drug
Isoproterenol — Isuprel (Winthrop Laboratories)

PRESENTING

Officers and Councilors Elected at the 1970 Annual Meeting

INSTALLATION CEREMONIES for the Incoming President of the Ohio State Medical Association were held at the final session of the House of Delegates on May 14, during the 1970 OSMA Annual Meeting in Columbus. At the same session, the House of Delegates named a President-Elect, elected one new Councilor and reelected five other Councilors and the Secretary-Treasurer. Following are brief biographical sketches of the President-Elect, the Incoming President, the new Councilor for the Fifth District, with additional information on other members of The Council.

Dr. P. John Robechek, of Cleveland, was named President-Elect of the Association and will be installed as President at the 1971 Annual Meeting to be held in Columbus, May 10-14. A practicing surgeon in Cleveland, Dr. Robechek is a diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons.



Dr. Robechek

He comes to the high office in the Ohio State Medical Association with a rich background of medical organization work. In 1960 he was installed as President of the Academy of Medicine of Cleveland, after serving in numerous other capacities in the local organization. He has served the maximum of three full terms as Councilor of the Fifth District. On the state level also he has served as chairman of the Auditing and Appropriations Committee, and as chairman of the Multidiscipline Committee of the OSMA which drafted the nationally recognized document "Essentials for a Comprehensive Home Care Program." In 1961 he was named an Alternate Delegate to the American Medical Association and has since been elected a Delegate, an office which he now holds.

In other professional organization activities, he was President of the Medical Staff of St. Luke's Hospital, was head of the Surgery Department at Marymount Hospital, a member of the Ohio Cancer Coordinating Committee, Liaison Fellow for the Fifth District, Cancer Commission of America — American College of Surgeons. He is currently Treasurer of the Ohio Chapter, American College of Surgeons, and is a member of the Cancer Committee, Northeastern Ohio Regional Medical Planning Committee.

A native of Cleveland, Dr. Robechek received his bachelor's degree from Adelbert College, Case Western Reserve University, and his medical degree from Case Western Reserve University School of Medicine in 1940. He served on active duty with the Navy as a medical officer from 1944 to 1946. He is a trustee of Blue Cross of Northeast Ohio and a member of its Medical Advisory Committee. He is a member of the Medical Arts Club, the Aesculapian Society, and the Presbyterian Church.

He is married to Ruth Driggs. Their three children are Mary Dow Ross, of Madison, Wisc.; Sara K. Robechek, of Cleveland, and John D. Robechek, engineering student at Cornell University.

Incoming President

Dr. Richard L. Fulton, of Columbus, was installed as President of the Association at the final session of the House of Delegates and assumed office at that time. He was named President-Elect at the 1969 Annual Meeting after serving as Councilor of the Tenth District since 1963.

Dr. Fulton is a practicing physician in Columbus, specializing in internal medicine. He is a diplomate of the American Board of Internal Medicine and is associate clinical professor of medicine at Ohio State University College of Medicine.



Dr. Fulton

A native of Miamisburg, Montgomery County, he received his A.B. degree from Wittenberg University, Springfield, and his M.D. degree from Ohio State University college of Medicine in 1944. After an internship at Miami Valley Hospital, Dayton, he entered military service and served with the Army in Germany.

Dr. Fulton is a past president of the Academy of Medicine of Columbus and Franklin County, has served on numerous committees of the Academy's Council. He was Columbus area of the "Sabin on Sunday" polio vaccine campaign chairman and received special commendations from the United Appeals organization and from the mayor of Columbus for his part in the success and effectiveness of that campaign. He also was chairman of the Columbus Area Community Health Committee.

He served as a delegate of Franklin County to the Ohio State Medical Association House of Delegates and in 1963 was elected a member of the OSMA Council as Councilor of the Tenth District. On the state level, he has served in several strategic positions; was on the OSMA Committee on Auditing and Appropriations, was advisor to the Ohio State Society of Medical Assistants, on the Liaison Committee to the Blue Shield program, and was chairman of the Nominating Committee for members of the Board of Directors of Ohio Medical Indemnity.

Dr. Fulton is a Fellow of the American College of Physicians. Among other professional affiliations, he is associated with the Columbus Society of Internal Medicine, the American Medical Association, American Heart Association, and American Diabetes Association. He has served as president of the Central Ohio Diabetes Association.

Hospital appointments include those at Riverside Methodist Hospital, where he is chairman of the Medical Records Committee and coordinator of Outpatient Medical Clinics; University Hospital, where he is associate clinical professor of medicine; Mt. Carmel, Grant, and St. Anthony Hospitals.

In community activities, he is a past president of the Metropolitan Health Council, former member of the Kiwanis Club (Northwest), former medical advisor to the Columbus Chamber of Commerce, past vice-president of the United Community Council, former chairman, Professional Division of the United Appeals, and member of the Screening Committee of United Appeals. In 1962 he was named by the *Columbus Citizen-Journal* as one of ten outstanding men for his activities in the Sabin-on-Sunday program.

Fraternal organizations include Alpha Tau Omega (past president), Phi Chi (past president), Pick and Pen, Skull and Chain, Blue Key Honoraries at Wittenberg.

Dr. Fulton is married and the father of one son.

(Continued on Next Page)

Fifth District Councilor

The House of Delegates elected Dr. David Fishman, of Cleveland, as Councilor of the Fifth District to succeed Dr. Robechek.

Dr. Fishman is a practicing physician in Cleveland, specializing in internal medicine with emphasis on gastroenterology and is assistant clinical professor of medicine, Case Western Reserve University School of Medicine. He is a past president of the Academy of Medicine of Cleveland, has served on its Board of Directors, and has served a number of terms as delegate of the Academy to the OSMA House of Delegates.



Dr. Fishman

He received his early education in the public schools of Cleveland, graduated from Adelbert College, Western Reserve University, earned a masters degree in physiology from Ohio State, and was awarded his M. D. degree by the OSU College of Medicine in 1937.

His internship was at St. Luke's Hospital, Cleveland, and was followed by residency training at Lakewood City Hospital. After a tour of active military service during World War II, he took additional residency training in gastroenterology at the Massachusetts General Hospital, Boston.

Among hospital appointments, Dr. Fishman is senior associate physician, St. Luke's Hospital, Division of Medicine; head of the Department of Gastroenterology, St. Luke's, and assistant physician in the Division of Medicine, University Hospitals, Cleveland.

In addition to his numerous services to the Cleveland Academy, Dr. Fishman has served on the Judicial and Professional Relations Committee of the Ohio State Medical Association. In other professional activities, he is a member of the American Medical Association, a founding member of the U. S. Committee of the World Health Organization, Fellow of the American College of Gastroenterology, Life Member of the American College of Physicians, member of the American Society of Internal Medicine, the Ohio and Cleveland Societies of Internal Medicine, the Western Reserve Medical Directors Association. Also he is a member of the Ohio Committee for Voluntary Health Planning and chairman of its Subcommittee on Legislation; and governor of the State of Ohio, American College of Gastroenterology.

Among community activities and honors, he is director of medical relations for the Blue Cross of Northeast Ohio; president of the Cleveland Neighborhood Health Centers, Office of Economic Opportunity (Hough-Norwood); former president of Shaker Heights Association for Retarded Children; former trustee of the Cleveland Health Museum; member of the Executive Board and officer of the Comprehensive Health Planning Corporation; member of the Board and vice-president of the Northeast Ohio Regional Medical Program; member of the Board of Trustees, Cleveland Medical Library; chairman, Finance Committee of Metropolitan Health Planning Corporation; and member of the Research Committee of Physicians of Research and Planning Department, Blue Cross of Northeast Ohio.

Dr. Fishman has made a number of contributions to the medical literature and has collaborated on articles in his specialty field for the *American Journal of Physiology,* the *Journal of the American Medical Association, Annals of Internal Medicine,* and the *American Journal of Gastroenterology.*

Dr. Fishman's office is at 10515 Carnegie Avenue, Cleveland, and his home at 2620 West Park Blvd., Shaker Heights. He is married to Florence Rice and has two sons.

Other Members of The Council

As Immediate Past President, Dr. Robert N. Smith, of Toledo, will serve an additional year on The Council.

Dr. James L. Henry, of Grove City, was reelected to his office which is designated Secretary-Treasurer under the new Constitution and Bylaws. The term is for three years.

Dr. Paul N. Ivins, Hamilton, was reelected Councilor of the First District. He was first elected to that office in 1966 and reelected in 1968.

Dr. Dwight L. Becker, Lima, was reelected Councilor of the Third District. He was first elected to that office in 1968.

Dr. Sanford Press, Steubenville, was reelected Councilor of the Seventh District. He was first elected to that office in 1966 and reelected in 1968.

Dr. Oscar W. Clarke, Gallipolis, was reelected Councilor of the Ninth District. He was appointed to that office by The Council in September, 1966, to fill part of the first year of an unexpired term, and was elected by the House of Delegates in 1967 to complete the remaining year of the unexpired term. He was reelected in 1968.

Dr. William R. Schultz, Wooster, was reelected Councilor of the Eleventh District. He was first elected to that office in 1965 to fill one year of an unexpired term, and was reelected in 1966 and 1968.

Councilors in the midst of two year terms are Dr. George J. Schroer, Ft. Loramie, Second District; Dr. George N. Bates, Toledo, Fourth District; Dr. Maurice F. Lieber, Canton, Sixth District; Dr. William R. Wells, Newark, Eighth District; and Dr. James C. McLarnan, Mount Vernon, Tenth District.

Dr. Leon Schiff, University of Cincinnati Medical Center physician and scientist, and widely recognized for his research and publications on gastrointestinal and liver diseases, is scheduled to retire with the title of professor emeritus of medicine, August 1. He has accepted an appointment as director of the new Liver Center at the University of Miami, Florida.

ON THE OMPAC*AMPAC FRONT

Just What Is the PAC Movement, and What Does It Do?

Some physicians apparently have a misconception about the purposes and activities of the Ohio Medical Political Action Committee and its national counterpart, the American Medical Political Action Committee.

Here are the facts to set the record straight on two areas of misunderstanding.

First, OMPAC and AMPAC do not make policies regarding legislation of interest to the medical profession. Such policies are developed by the Board of Trustees of the American Medical Association under edicts laid down by the House of Delegates of the AMA and by The Council of the Ohio State Medical Association under policies set by the OSMA House of Delegates.

AMPAC and OMPAC are separate organizations with their own governing boards. They do not make legislative policy. They do not engage in lobbying. They are concerned solely in political action—namely, electing people to public office—and in political education activities.

Naturally, information which the AMA and OSMA may have regarding the qualifications and views of candidates is carefully analyzed by the governing boards of AMPAC and OMPAC before decisions are made on which candidates should be supported.

Second, part of the contributions received by OMPAC from Ohio physicians is turned over to AMPAC to use as the national organization sees fit. Some of these funds are returned to OMPAC. Some are contributed to medical political action committees of other states where money is badly needed to assist qualified candidates.

Actually, it is important so far as Ohio physicians are concerned to have a good man elected to national office in Utah, Wyoming or any other state. His vote counts just as much in the Congress as that of an Ohio Congressman. The same applies within Ohio on a county-to-county or district-to-district basis. OMPAC is concerned with the election of qualified candidates regardless of state, county or district.

By pooling contributions received and dispensing them on the basis of need, AMPAC and the various state political action groups formed by the medical profession are able to strengthen their effectiveness in the political arena.

Ohio Medical Political Action Committee

The President's Address

By Robert N. Smith, M.D., Toledo

THIS HAS BEEN A BUSY YEAR. The pace of activity has increased week by week, and month by month. It has been a year of contrast. Accomplishments have been made, failures did occur. Endeavor was matched by frustration. Peace and beauty were the cry—turmoil and ugliness the fact. Understanding was sought—misunderstanding occurred. Personally, this year has contained the saddest days of my life, and the happiest days of my life. The profession has honestly tried to meet many new demands for medical services. Yet it has been castigated by government and vilified by the CBS television system.

We find ourselves assembled at the 122nd Annual Meeting of the OSMA to discuss, deliberate, and decide the issues which affect our profession. We do this in an atmosphere of change, doubt, and turmoil, not only within the profession, but on the college campuses, in the halls of Congress, in the business world, and within the citizenry as a whole. Fundamental values in all areas which were absolute a few years ago, are being challenged. In medicine, our traditional and time proven methods of medical care are being vigorously questioned. Some would have us scrap the whole system, or "non-system," as the "in-group" describes our medical care procedures. The profession admits the health care system is not perfect. But it is attempting, through critical self-analysis, to improve health care delivery without destroying the proven concepts of our present system. In an atmosphere such as this it is easy, even satisfying, to allow emotion to rule. However, I know, we will decide the issues and elections at this meeting objectively and unselfishly, bearing in mind what is best for our patients, and what will continue to improve and advance the medical profession.

Membership and Planning

When I spoke with you at last year's Annual Meeting, I made certain proposals which I felt were needed by the State Association. Some of these have been accomplished. Some are in progress. The matter of increasing membership and the participation of members has been pursued by the formation of a membership and planning committee. This committee has been charged with determining the needs of our physician members in the years of the 1970's.

The Committee conducted a comprehensive survey of the membership, the results of which were published in the May 1970 *Journal*. Fifty-five percent of the membership responded—extraordinary when one considers that 20 to 25 percent is a good response. Of those responding, one-half took the time to write comments about the OSMA and the AMA. We got our share of bouquets and brickbats, but in general the response was favorable. We are forwarding the comments about the AMA to Chicago. The preliminary information gleaned from the survey has been transmitted to the appropriate committees of the society for in-depth study and recommendations. The comments about the OSMA and the AMA have been difficult to analyze in their essay form. However, the thoughts of doctors about their associations deserve detailed attention.

I believe a second survey should be conducted. The questions of this survey should be constructed from the present comments. The data from this latter survey would then be subject to computer analysis.

More Effective Communications

Individual doctors form their image of the society largely through what they hear and read. Improvement in these channels of communication was accomplished by conducting an intensive public speaking course for the Council, the AMA delegation, and the county society presidents. The enthusiasm at these meetings was remarkable. Every man completing the course is, I know, a more effective communicator—to his society membership, to the press and TV, to the general public. Our other major endeavor in communication was to upgrade *The Journal* by changing its format, redesigning the cover, and improving its content. The readership, I am told, is increased significantly. Our membership has grown some, but more importantly, the apathy which existed among our members has been converted to involvement.

In order to encourage better cooperation with our specialty groups, a survey was conducted asking how we could assist the specialty groups in their work. As a result, *The Journal* now carries a listing of specialty meetings in Ohio. Also, there

Presented before the Ohio State Medical Association House of Delegates, May 11, during the 1970 OSMA Annual Meeting in Columbus.

has been excellent cooperation with the specialty groups in preparing the scientific section of the Annual Meeting.

Dialogue with the Deans

I suggested last year that we work toward a closer relationship with the academic community. The deans of Ohio's four medical schools were invited to attend two meetings of Council during the year. These meetings produced friendly, forthright, frank discussions. Many of the bugaboos which have separated us were exposed and eliminated. We found the deans were not locked in ivory towers; they found we were not locked in bank vaults.

The deans share our concerns about the supply of physicians. Plans for the next five years will increase enrollment in Ohio medical schools to about 750 students per class. A yearly graduating class of this size should meet Ohio's need for physicians. But, only if communities, chambers of commerce, county medical societies, medical school faculties, and local physicians convince these graduates that there is an attractive, satisfying place for them to practice in Ohio. I would recommend that county societies and medical schools set up a buddy system between local physicians and medical students from the first day of medical school.

In the area of graduate and postgraduate education significant progress has been made. Our work with the specialty societies has been mentioned. Of greatest importance is the transformation of the Committee on Education to the Commission on Medical Education, which is composed of:

(1) The old Committee on Education;

(2) Deans of the four medical schools;

(3) Coordinators of the four Regional Medical Programs;

(4) Chairman, OSMA Committee on Scientific Work;

(5) Chairman, OSMA Section on Direction of Medical Education.

This Commission is charged with an overall analysis of the medical education system including curricula and manpower needs, both physician and paramedical personnel. The Commission is exploring continuing education on the basis that medicine is a 50-year curriculum. The Commission has not begun, as yet, the development of a self-evaluation program. This will certainly be started in the near future.



Incoming President Richard L. Fulton pins the Past President's Button on Outgoing President Robert N. Smith at the final session of the House of Delegates.

Economic Research

During the year, we have developed a new department in the Association—a Department of Economic Research. Mr. Charles Price, with an MBA degree from Harvard, is head of this section. He was formerly Assistant to the Senior Vice President of *Medical Economics*. The Association, for the first time, is now able to develop our own statistics, and carry out independent analyses of statistics published by various government agencies. Such statistics were useful in my testimony before the Pottenger Committee during its investigation of Medicaid in Ohio. Other statistics developed by the department and pertaining to health care costs, physician incomes, and fees have been supplied to Senator Saxbe. An attempt is now being made to compare productivity and costs of medical care delivery under fee-for service practice and prepaid group practice. Robert J. Myers, until recently the chief actuary of the Social Security Administration, stated in a letter to the Association, "At the present time, we do not have any statistics to give a valid comparison of cost per person under prepaid group practice plans versus private practitioners for the aged population. On the other hand, using some crude existing data, we have concluded that the savings under prepaid group practice plans is definitely not as large as these plans have claimed and publicized in the news media."

Another program being planned will allow the Association to develop its own statistics about practice overhead costs and physician fees. With the cooperation of the doctors of Ohio, period economic surveys will be carried out. The survey data, which will be collected without revealing the

source, will provide an independent check against similar data collected by government agencies or other sources.

Relating to the Student

Medical students and their relation to the profession have been a serious concern. These young doctors of the future are well motivated—their deans attest to that. They want to talk with us about the profession—about their curricula—about actual practice—about morals and ethics—about decisions we will make at this meeting. In ten years many of them will sit where we sit now. Let us hear them out.

Another important area is our relationship with the Ohio Hospital Association. During the year three meetings of the officers of both associations were held with free and frank discussion of our common problems. We have supported their efforts to use paramedical personnel in hospitals with the support and acceptance of the medical staff. The OHA, in turn, has indicated the desire of hospital administrators to have increased participation by doctors in the functioning of the hospital. Together we wrote and jointly approved the following statement regarding hospital board membership:—

"Those persons elected or appointed to hospital governing boards should be qualified, interested individuals possessed of knowledge and expertise necessary for good trusteeship and should reflect a broad representation of the community.

"No person should be denied governing board membership because of occupation and hospital bylaws should endorse this principle.

"Physicians, as representatives of the community, should be eligible for membership on hospital governing boards in the same manner as are all other knowledgeable and effective individuals."

News Media

During the year we attempted to get our story to the various news media. We took the initiative when we had appropriate newsworthy material. When we were subject to attack we responded promptly, rationally, and positively. Our public relations department develops good copy. Unfortunately the news media does not always use it.

Dr. Fulton will cover the malpractice area in more detail. The simple fact is that the situation is serious, and no solution is apparent. Nor will it be, until the public becomes aroused about the 5 percent or so this adds to their medical costs.

Medicaid and Medicare have been investigated. The profession was made the scapegoat for the cost overruns. This, in spite of the fact, that no cases of fraud or overcharging were proven in Ohio. In the nation Robert Ball, Commissioner of Society Security, acknowledged that the cases of wrong-doing were insignificant. Once again, the government has struck unfairly at the profession with deliberate deceit.

The new Social Security bill reported out by the House Ways and Means Committee will limit benefits to Medicare recipients to the 75 percentile based on physician profiles for 1969. Increases in fees will be limited to increases in the C.P.I. (Consumer Price Index), rather than the more appropriate A.S.I. (All Services Index). Doctors who acted in good faith during 1968-69, by not increasing fees as urged by Wilbur Cohen, are now locked into 1968 fees. What other profession, industry or business is limited to 1968 prices with 1970 costs? Remember, if you take assignment you agree to accept the fee set by the government, 20 percent of which is paid by the patient. If you direct bill, the benefit is paid to the patient. Your contract remains with the patient—not the government.

Thoughts About the Presidency

Having now almost completed my term as president, I have some thoughts which I would like to share with you. Sometime ago the office was largely honorary, but gradually its responsibilities and authority have increased until now it could easily be a full time job. The forces which oppose free medical practice are professionally and ruggedly managed. To compete effectively we must also be so organized.

Candidates for the office of president may be limited by the present financial arrangements. I believe the association must soon consider an appropriate salary for the president so that the office may be filled by any qualified doctor in the association.

Again, in the interest of organizational efficiency, I believe the term of office should be extended from one to two years, or that the president should be eligible for reelection for one term.

In the beginning of the term, a couple of months are required to get the feel of the position. At the end comes a period of lame duckitis during which the effectiveness of the office is reduced. The actual period of service is thus about nine months out of the year's term.

Admittedly, there is a shortage of trained medical administrative manpower in the private sector of practice. I suggest that this shortage could be met from among the 50 state presidents who retire yearly, if further management training were made available to those who wish to pursue such a course. An AMA institute of management



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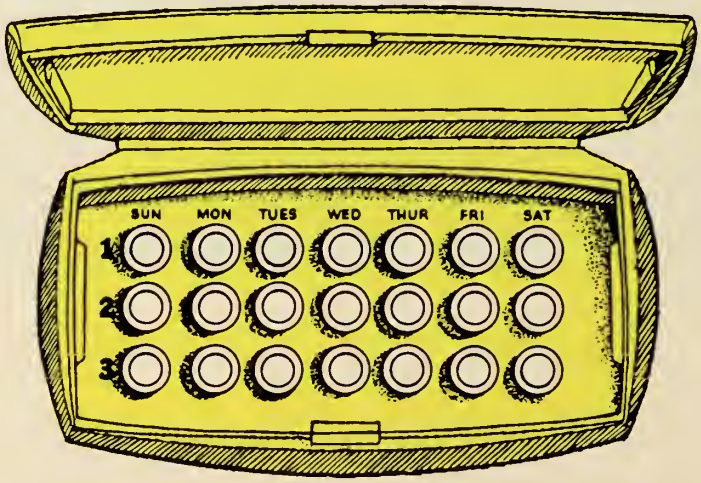
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ctions—Demulen acts to prevent ovulation by inhibiting the output of gonadropins from the pituitary gland. Demulen depresses the output of both the icle-stimulating hormone (FSH) and the luteinizing hormone (LH).

pecial note: Oral contraceptives have been marketed in the United States e 1960. Reported pregnancy rates vary from product to product. The effectness of the sequential products appears to be somewhat lower than that of l combination products. Both types provide almost completely effective conception.

In increased risk of thromboembolic disease associated with the use of hornal contraceptives has now been shown in studies conducted in both Great ain and the United States. Other risks, such as those of elevated blood pressle, liver disease and reduced tolerance to carbohydrates, have not been quanited with precision.

ong-term administration of both natural and synthetic estrogens in subprite animal species in multiples of the human dose increases the frequency of ne animal carcinomas. These data cannot be transposed directly to man. The sible carcinogenicity due to the estrogens can be neither affirmed nor refuted his time. Close clinical surveillance of all women taking oral contraceptives st be continued.

ndication—Demulen is indicated for oral contraception.

ontraindications—Patients with thrombophlebitis, thromboembolic disorders, ebral apoplexy or a past history of these conditions, markedly impaired liver iction, known or suspected carcinoma of the breast, known or suspected rogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Varnings—The physician should be alert to the earliest manifestations of mbotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary bolism and retinal thrombosis). Should any of these occur or be suspected drug should be discontinued immediately.

etrospective studies of morbidity and mortality in Great Britain and studies morbidity in the United States have shown a statistically significant associan between thrombophlebitis, pulmonary embolism, and cerebral thrombosis al embolism and the use of oral contraceptives. There have been three princi- studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The mate of the relative risk of thromboembolism in the study by Vessey and [3] was about sevenfold, while Sartwell and associates[4] in the United States nd a relative risk of 4.4, meaning that the users are several times as likely to ergo thromboembolic disease without evident cause as nonusers. The erican study also indicated that the risk did not persist after discontinuation administration, and that it was not enhanced by long-continued administran. The American study was not designed to evaluate a difference between ducts. However, the study suggested that there might be an increased risk of mboembolic disease in users of sequential products. This risk cannot be ntitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or nplete loss of vision, or if there is a sudden onset of proptosis, diplopia or graine. If examination reveals papilledema or retinal vascular lesions medican should be withdrawn.

ince the safety of Demulen in pregnancy has not been demonstrated, it is ommended that for any patient who has missed two consecutive periods gnancy should be ruled out before continuing the contraceptive regimen. If patient has not adhered to the prescribed schedule the possibility of pregncy should be considered at the time of the first missed period.

small fraction of the hormonal agents in oral contraceptives has been ided in the milk of mothers receiving these drugs. The long-range effect to the sing infant cannot be determined at this time.

recautions—The pretreatment and periodic physical examinations should inde special reference to the breasts and pelvic organs, including a Papanicou smear, since estrogens have been known to produce tumors, some of them lignant, in five species of subprimate animals. Endocrine and possibly liver iction tests may be affected by treatment with Demulen. Therefore, if such ts are abnormal in a patient taking Demulen, it is recommended that they repeated after the drug has been withdrawn for two months. Under the inence of progestogen-estrogen preparations preexisting uterine fibromyomas y increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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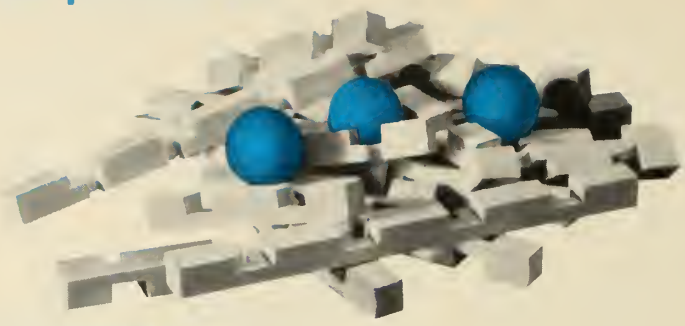
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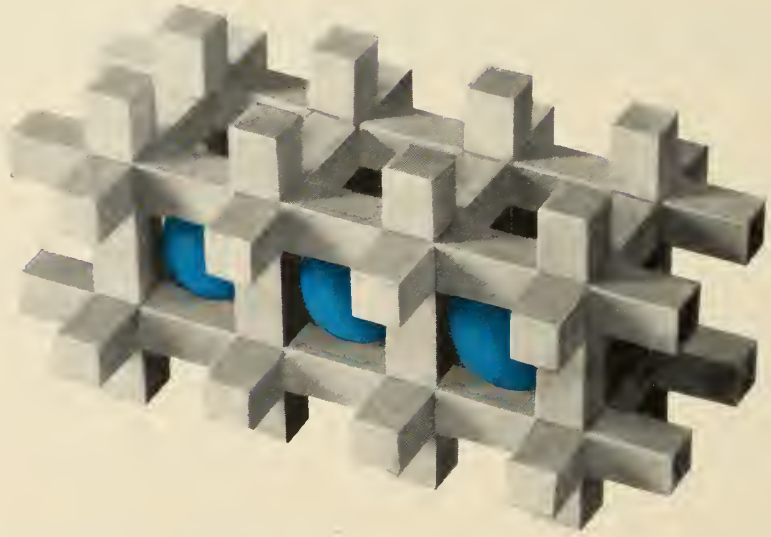
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Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warnings: Do not exceed recommended dosages.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

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How Supplied: Bottles of 100, 500 and 1,000 tablets.

References: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al: Hosp. Topics 39:71-73, 1961: (3) Haas, Jr., J., and Kay L.L.: Southwest. Med. 42:30-32, 1961 (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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could provide such postgraduate education. Graduates of the institute would be qualified to serve in government, industry or organized medicine. The important point is that the background of each graduate would be from the private practice sector rather than from the Public Health Service or the Armed Forces.

Effective Peer Review

Next, what should we expect in Peer Review? Simply stated—more peer review to include fees, quality of care, and quantity of care. Title XVIII and XIX require such review. However, it is in our own best interest to have effective peer review. For one thing, we are being reviewed by our own colleagues—not employees of government or a third party payee. Secondly, we can develop facts. As the cost of medical care rises, as surely it will, we will again be subjected to irresponsible criticism and to pressure for fee control. We must be able to prove factually that fees are proper; that the quality of medical care is good; that the amount of care is appropriate to the disease; and that good medical care is available to all. Unfounded criticism will shrivel in the hot light of facts. Private practice will survive because it is doing the job, and can prove it.

This has been a summary of some of the activity during my term. Needless to say, many people were involved and to all of them goes my thanks and appreciation. In particular, I want to thank the members of Council, the officers, the staff—Hart, Chuck, Herb, Jerry, Bob, Gordon and the girls; my anesthesia group and, last but not least, my family. I will support our new president with all my energies in whatever tasks he may assign to me. Many things are yet to be done. Some things were done which ought not to have been done. But what was done I did to the best of my ability.

Many of the proposals I have discussed involve relationships between persons or groups.

A new minister in town—Robert Raines of First Community Church—has taught me that no worthwhile relationship can exist unless we first are able to look beyond our prejudices and behind external characteristics to the human being. Mr. Raines pointed out that, too often, we see a grouchy face and forget that behind it is a human being. Hello human being—good-bye grouch. Hair in the youth turns us off. Try "Hello son," "Good-bye hair."

And tonight I say to you, "Hello Human Being."

Hello Doctor	Good-bye Superman
Hello Doctor	Good-bye Black Man
Hello Doctor	Good-bye White Man
Hello Dean	Good-bye Ivory Tower
Hello Colleague	Good-bye LMD
Hello Future Doctor	Good-bye Medical Student Radical
Hello Patient	Good-bye Poor Man
Hello Patient	Good-bye Rich Man
Hello Lawyer	Good-bye Contingency Fee
Hello Patient	Good-bye Malpractice Suit
Hello Hospital Administrator	Good-bye Antagonist
Hello OSMA Member	Good-bye Apathetic Doctor
Hello Toledo	Good-bye Columbus
Hello President Fulton	Good-bye President Smith



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Inaugural Address

By Richard L. Fulton, M.D., Columbus
1970-1971 President, Ohio State Medical Association

Presented before the House of Delegates of the Ohio State Medical Association during the 1970 Annual Meeting.

YOU HAVE ALL HEARD of the accomplishments of the OSMA last year. A lot has been done and there is a whole lot more to do. How about our future? Charles Kettering once said that "My interest is in the future because I am going to spend the rest of my life there." Where do we go from here?

The Picture

You know—frequently we talk about the art of medicine. "Art is not an end in itself, but a means of addressing Humanity."[1] So let's address Humanity and let's you and I together employ some art and let's paint a picture. What medicine is today, what it probably will be tomorrow.

Very prominent in this picture is a two-headed governmental blunder—Medicare and Medicaid. These programs were a mistake in execution and they were a mistake from beginning to end. In no way have these programs worked as promised by the government. Our State Medical Association estimated that they would cost about three hundred percent more than the government said—but we were wrong. They cost four hundred percent more. We do thank Dr. Paul Metzger and Mr. Hugh Hughes, of Nationwide Insurance Company, who are doing all they can to make Medicare as palatable as possible. We hope they continue. We also hope that the government learned something from these programs before we paint in our next picture.

Cloud on the Horizon

That's a dark cloud on the horizon. It is National Health Insurance. This program is coming. We don't know how rapidly or when it's going to get here, but it's coming. Even Health, Education and Welfare says that our country is not ready for it yet. This won't make any difference to those politicians who think that their political aspirations might be sooner realized if they can get on the bandwagon and help develop such a program.

As medical men, more and more, it seems to me, we are being ignored regarding medical matters in this country. The AMA offered to help CBS in its several programs. This offer was spurned. "Our minds are made up, don't confuse us with the facts," might be the motto assumed by CBS.

After these programs, a medical student called me and said, "Dr. Fulton, surely, surely some physicians must care about their patients, don't they?" And he was real sincere. If a medical student has this sort of question, what kind of questions do you think the general public has? These programs, and all of us, I am sure, will agree, were prejudiced. Webster said that prejudice is "a judgment or opinion formed before the facts are known. It is a preconceived and unreasonable judgment or opinion."

We would like to set the records straight. As Dr. Howard said, up to now we have sort of struck out of the ball game since our requests for time have been denied. I still think attempts should be made to counterattack the CBS programs.

Now, down in the lower right-hand corner of our picture are a few letters—R.M.P.—Regional Medical Program. As you know, this program originated to concern itself with "heart, cancer and stroke." Then, as medicine predicted, they added "and related diseases." Up to now, as far as I know, three diseases are officially "related"—diabetes, renal disease and emphysema.

I have personal knowledge of our local program as I am on the advisory committee to the Ohio State program, which encompasses sixty or sixty-one counties. I will say that it is well organized. It is well monitored. I just hope the other fifty-four programs in the United States are in as good hands. But, you see, if everybody wants a piece of this pie—and they might—this program then could get way out of hand and it could cost us billions of dollars.

Along with these there are three other letters, C.H.P. This stands for Comprehensive Health Planning. These two programs are first cousins and there are a lot of duplications. The wagering odds are that one of them will absorb the other

[1] M. P. Moussorgsky

one. This will be interesting to watch—and watch it we should.

Psychedelic Panorama

Now, the upper left part of this picture is very hazy, almost psychedelic. And there appears a conglomeration of syringes and needles, tablets, capsules, words, phrases—this represents our drug problem. This part of our picture changes weekly and it enlarges as more and more people adopt this debilitating habit. Several months ago Joan and I attended a program sponsored by the Cleveland Academy of Medicine. It was a three-day seminar and it was excellent. One of the outstanding parts of this program was a movie which was prepared by the Chairman of the Pharmacology Department of the University of Michigan.

In this he used monkeys as the experimental animal and he had an ingenious device whereby he could give these monkeys a drug at will, or the monkeys could give themselves a drug at will. The outstanding part of this movie was a picture of a monkey having a withdrawal reaction from barbiturates. This was the most terrifying sight that I have ever experienced. Blood was dripping from the monkey's left wrist and it was dripping from its left wrist because the monkey had chewed off his own left hand in an attempt to satisfy his insatiable desire for barbiturates.

Lord Byron said, "Ah, happy years! once more who would not be a boy!" and I wonder about this. Whatever happened to the kids that used to play mumblety-peg and shoot marbles on the way home from school?

I fear sometimes that a sixteen-, seventeen-, or eighteen-year-old might come to my office and say, "I am on dope—help me."

What would you do? Where would you do it? How would you do it? It seems to me that somehow the drug user who seeks professional help must be shown complete confidentiality without the fear of prosecution, and we as physicians must be able to treat these people with the same guarantee.

Price Tag on Integrity

Our picture is growing, and now I see a huge dollar sign. This represents two things. It represents premiums that we pay for our malpractice insurance and it represents settlements that are made in malpractice suits. Why are these so high in the United States and so low in Canada?

During this past winter, I was fortunate enough to meet a highly reputable Canadian attorney and I asked him this question. He did some researching and this is what he told me. First of all, the number one reason, is the contingency fee. This started out, as do many issues, on a very good fundamental basis with good intent. It was to assist individuals who could not afford an attorney. It assured them legal representation. However, like many other things, it became twisted and now it is used for other than its original intent.



Incoming President Richard L. Fulton presents the Inaugural Address before the House of Delegates.

In Canada, a contingency fee is illegal. It is unethical and it is prohibited by statute in Ontario.

Do you know that most Canadian physicians don't even have malpractice insurance? They belong to a group that is called the Medical Protective Association. They pay $35.00 per year to belong to this organization. It is a voluntary group but it **always** pays the expense of an attorney if the physician is sued and it **always** pays judgment in case the physician loses.

Now there are a few physicians, who may doubt that this Association will maintain its record and so they buy insurance. I might add, one can't have insurance and also belong to the Medical Protective Association. You can't have both.

If you do get insurance, the general practitioner and the general surgeon will pay $53.28 per year. The orthopedic surgeon pays $106.56 per year. This is for $200,000-$600,000 coverage. How does this compare with your malpractice rates?

In Canada, they try a physician only with a judge, not with a jury. Often the judge will ask an eminent physician to sit with him during this trial to answer professional questions.

What can we do about this? We did talk with Mr. Bitner Browne who is President of the Ohio State Bar Association. He felt that there was no way that the contingency fee could be eliminated

because too many members of his organization are plaintiff attorneys and utilize contingency fees.

We then considered the proposition that maybe the Ohio State Medical Association should sponsor its own program or, at least, recommend a single insurance company for coverage. With this in mind we met with the President of the Medical Protective Company of Indiana. This company insures about sixty-five to seventy percent of the physicians in Ohio. It felt that OSMA was too small and said that states such as Texas, Michigan, Pennsylvania have considered such programs and have ruled them out.

The company mentioned that Oregon, Oklahoma, California, New Jersey and Florida have adopted such programs and they have all had very sad experiences. Florida has just had a three hundred percent increase in premiums. There's a lot to be done regarding malpractice insurance. I don't have the answers. I do promise you that we shall explore every possibility for solutions during this coming year.

Our Future Doctors

And now I see a multitude of faces. These are the medical students of today. They're probably smarter than we were. I am not real sure. At least, they verbalize better. They don't take as much for granted as we did. The "Gospel Truth" doesn't mean a whole lot to them. They are much more interested in community and social problems than they are with the medical problems of the individual.

They are motivated—and this is good—and I charge each of the medical students who might be here tonight with the responsibility of maintaining his motivation after he graduates. I hope all of the students keep their enthusiasm for the delivery of health care. If they join us in taking care of patients, **God bless them all.**

I think that some of the students' ideas are premature. This reminds me. On the way to the Sheraton tonight I saw an old man standing on the street corner and I said, "Old man, have you lived in Columbus **all your life?**" and he said "Nope—not yet."

Recently Joan and I visited our son at Wittenberg University during parents' weekend. It is one of the few colleges that is still functioning. Students and faculty have worked this out very well. We had some sit-ins, learn-ins, etc. and they were great. I came to a few conclusions.

First of all, there are a few students who should not be students and there are a few members of the faculty who should not be on the faculty and there are a few parents who should not be parents. Most of the people concerned were earnestly trying to logically solve these problems—to make the future better for all of us.

Sam Devine came. He was called Friday afternoon. He thought that Wittenberg was doing such an outstanding job that he cancelled all of his commitments and came to Wittenberg Saturday afternoon. He has officiated many football games and he made an important point.

"In a football game, when a player steps on the side line marker, he's out of bounds." Now he can rant and rave all he wants to, but he is out of bounds. He's out of bounds because the rule book says he is out of bounds. Clobbering the guy in the striped shirt is not the answer. Now—if this player feels the rule is wrong, then let him talk with others, discuss it, argue it in a nonviolent way and get the rule changed. But as long as the rule says he is out of bounds, **he is out of bounds.**

I propose a few things in this regard. **First of all**—I think we should change the format of the Annual Conference that we give for the Junior Medical students and their wives or girl friends. This last one was pretty flat. We had sixteen attend the one in Columbus. Twenty-two attended the Conference in Cincinnati.

Second, I wonder if the material that we usually present at this conference could be included in the curriculum at the Medical Schools. Given for credit. It's just an idea.

Third, I think we should appoint a liaison committee—no—four liaison committees, one in each city in which there is a medical school and a SAMA chapter. Let's make these liaison committees the responsibility of the Councilor in each District. Let's have these committees meet with similar liaison committees of the SAMA chapters. The Councilor could then report to the Council at its regular meetings. We would also be glad to honor the personal requests from representatives of SAMA to appear before the Council should they have some relevant material to present. I think during the next year this is a must, and I would like to so move.

Smudge

And now on the picture, is a smudge. This is pollution.

"Now fades the glimmering landscape on the sight and all the air a solemn stillness holds . . ."[2] A solemn stillness, because perhaps—nothing—no one will be alive. Dr. Smith has alluded to this as a possibility. This is an important subject and we, as physicians, as human beings, cannot sidestep this issue.

Now, I am going to paint a **table.** I am going to put numerous physicians around it. In the center, I am going to put a sign that says "Peer Review Committee." We have a lot of third parties now. They feel it is their responsibility, whether it is or not, to tell us whom to treat, how

[2]"Elegy in a Country Churchyard," by Thomas Gray

to treat them and how much to charge, etc. Now—if we as physicians need reviewing, and I guess we do, I certainly would prefer being reviewed by my peers, by physicians, rather than by nonphysicians. I hate to tell you this, but there are a few physicians that don't play this game according to Hoyle, nor Sir William Osler for that matter.

Council talked to a physician who regularly charges $60.00 for a night hospital visit. We know of a physician who treated an accident case three times a week for three years before he was questioned. We know of a physician who contracted with fifteen nursing homes. Each of these had approximately fifty patients so he would visit the patients, all of them, in three nursing homes each day. He would cover all fifteen homes during the week. Even though these were gang visits, he charged $10.00 per patient per visit.

Simple mathematics shows that had this continued, this physician would have earned $1500.00 per day, $7500.00 per week, $375,000 per year—and he wouldn't even have had to work on weekends. This is a true case. I think that maybe some counties, the smaller counties, aren't equipped or staffed to have a Peer Review Committee. I throw out a suggestion—possibly the District should conduct a Peer Review Committee for smaller counties. I am just suggesting this so we can think about it.

Medical Assistants

Now at the bottom of our picture is a path. There is a boy and a girl holding hands as they walk along this path. They are friends because one is a Navy Corpsman and the other is a Medical Assistant and they are both eligible to become Physician Assistants.

This is a program which we hope will increase in Ohio. These people will perform those jobs which require less training to do than is necessary to become a physician. Bob Smith has told me that he is very interested in this program and has promised to spearhead development of the program in Ohio during the next year.

Now we see a weary, family practitioner in our picture. He is weary because there aren't enough physicians like him. How are we going to produce more? I don't know. Specialty status, Board certification may help. I doubt that they will be the whole answer.

Next in our picture appears a few gleaming, white buildings. These represent the hospitals. We have worked closely with the Hospital Association during this past year and certainly will continue to do so in the coming year.

Our painting also shows a football field, a baseball diamond and a basketball court. These remind us that Dr. Sol Maggied and his committee on Sports Medicine have a big challenge. They must develop a program of regulations regarding training methods, etc. for all of the high schools and junior high schools in the State of Ohio. Too many deaths have occurred in Ohio and this must stop. Sol has a big job.

I am not going to frame this picture now, because it is going to grow. I am going to name it, though, and I am going to call it "Together We Care"—and We Do. We care about our patients. We want to give them the best medical treatment that we possibly can. We care about our families and we want to provide for them. We care about ourselves, and we should. We are humans and we have rights. We care about our profession and its future and that's why all of us are here tonight. We care, and because we care, we do. Woody Hayes says, "The shoulder shruggers are never the guys that go out for the team. It's the kids who care that do."

The Brighter Side

Obviously, there are many other items that we could include in our picture but there is only one more that I want to add. This is a great big, round, warm, glowing orange sun. And I am going to put it right in the middle of the picture. And it is going to brighten all the corners of our picture as it eminates its rays. It is going to erase the smudge and it is going to penetrate the psychedelic haze. This sun represents the goodness and the happy feeling that **most** of us have **most** of the time for **most** of the people. It represents hope and joy and love and thankfulness. Smoke Crawford used to say, "Sure it's a great day, I woke up this morning." Brother Dave Gardner says "Complaint is poverty and Happiness is richness and the worst I ever had was wonderful."

We are so often involved with all that we do and have to do that we forget to enjoy what we do have. So let's care together and do together and enjoy it. Let's not **forget** what we have.

I do forget things. I forget anniversaries, birthdays, etc. A couple of months ago at the breakfast table, Joan said, "Rich, you do know what day this is, don't you?" Wow—I had no idea what day it was but I mumbled something and left the house. After I arrived at the office, I called up and had a five pound box of candy delivered to Joan. The more I thought about it, the more concerned I became and so I ordered four dozen roses to be delivered. I still was unhappy and just didn't know what to do. On the way home, I stopped and bought a present just for insurance. As I walked in the house, Joan came up with tears of happiness in her eyes. She threw her arms around me and said, "Oh, Rich, this has been the happiest Ground Hog Day I've ever had."

Happy Ground Hog Day!

Two Ohio Physicians Honored w

Citations Presented in Behalf of the Ohio State Medical Assoc

IT IS WITH A DEEP FEELING of appreciation and gratitude that, on behalf of this association, we give recognition to a physician who has distinguished himself and this Association among his peers and has dedicated untiring efforts toward improving maternal health.

This House of Delegates, on April 23, 1953, expressed the profession's concern at the number of maternal deaths occurring in this state. As a result of this concern, a resolution was passed directing the Council to appoint a committee to explore the feasibility of establishing a Committee on Maternal Deaths, whose function would be to study, analyze and report on all maternal deaths in Ohio.

This committee was appointed and, under the chairmanship of one of the originators of the Franklin County Study, on January 16, 1954, reported its findings to the Council, resulting in the establishment of a Committee on Maternal Health.

Under the guidance of the physician we are honoring, this committee has, since 1954, been the most active committee of the State Association. This committee, in January of this year, held its 52nd formal meeting.

This committee has had but one chairman during its 16 years of existence. This indicates not only a dedication and devotion to a cause, but also indicates the confidence that 16 previous presidents and Councils have had in this man in getting a job done.

This man has provided the primary thrust for the development of the Ohio Maternal Mortality Study. He has had help, to be sure, but had he not so freely given of his time, one wonders if there would presently be a State Study.

It was recognized early that just collecting data on maternal deaths was not enough. There had to be a system for fast tabulation and analysis. This man had the preception, before computers became popular, to put the collected information on IBM cards making possible a data system for quick tabulation of data. Many will agree that the Ohio Study is second to none.

Through the direction and leadership of this physician, information has been collected and tabulated on over 1,500 maternal deaths which have occurred in Ohio since 1955.

The educational information gleaned from the study has been utilized in many ways. This chairman has either prepared or assisted in writing



Dr. Ruppersberg

over 100 articles for the Maternal Health Column in the *Ohio State Medical Journal*. He has presented programs on maternal health to many county medical societies. He has also spearheaded an annual maternal health exhibit at the OSMA Annual Meeting.

His recognition as an authority on maternal health is not limited to the confines of this state. Within the past month he has been on programs in Chicago, New York and Dallas.

He personally maintains a mailing list which is used to distribute reprints to more than 200 interested individuals in the United States, Canada, Ireland, and as far west as Australia.

As most of you will agree, recognition by your peers is a cherished honor. On the occasion of the 50th meeting of the Committee on Maternal Health in January, 1969, the Council and individual members of the committee surprised this physician by honoring him for his outstanding leadership and contributions made in the field of maternal health.

His published articles have been many and his accomplishments are legendary.

(Continued on Page 710)

Presentations were made by Robert N. Smith, M.D., OSMA 1969-1970 President.

Distinguished Service Citations

he House of Delegates, Meeting in Columbus on May 11, 1970

FOR MORE THAN 30 YEARS, a devoted, extremely active member of the Ohio State Medical Association has channeled his talent and energy for the betterment—healthwise—of one of America's prize assets—ITS YOUTH.

Dr. Tom Shaffer has been one of the most devoted members of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association since its formation nearly ten years ago. Many of his recommendations for the health and safety of scholastic athletes have been adopted by the Ohio High School Athletic Association, and his papers have been distributed widely among team physicians, coaches, trainers and administrators.

Tom has been a leader for several sports medicine conferences sponsored by the Joint Advisory Committee. A timely example is "The Health Team—For Better Athletics, Better Living"—the program to be held at Veterans Memorial Building tomorrow morning. He will moderate the discussion period following the individual talks.

For the past year, Tom Shaffer has chaired the American Medical Association's Committee on the Medical Aspects of Sports. During this time, he has managed to become a movie star—by portraying a physician giving preseason physical exams in the AMA production "The Team Physician."

His vast reservoir of knowledge and practical experience in the entire spectrum of pediatric medicine has benefitted the OSMA Committee on School Health for the many years he has served. This includes a five-year term as chairman from 1955-60. For example, he has closely followed the progress of state legislation concerning immunization of school-age children—and on many occasions has provided medical advice vital to OSMA consideration of the legislation.

Tom is presently director of adolescents' Health Services at Columbus Children's Hospital —a position he has held for six years. For 20 years, he has served as a professor in the Department of Pediatrics and Department of Preventive Medicine in the College of Medicine, the Ohio State University.

Another highlight of his professional career was a term from 1960 to 1964 as director of medical services for the Juvenile Diagnostic Center of the Ohio Youth Commission in Columbus.

His list of memberships reads like a "Who's Who." To mention a few highlights, he is a member of the American Academy of Pediatrics Joint Committee on Physical Fitness, Recreation and Sports; a member and past chairman of the Sci-



Dr. Shaffer

entific Advisory Committee of Buckeye Boys Ranch, a member of the Ohio Committee for the 1970 White House Conference and Midwest Society for Pediatric Research, a member of the Ohio Advisory Board on Smoking and Health, and past president of the State Planning Committee for Health Education in Ohio. The latter organization conducts the annual Ohio Conference on Physicians and Schools.

A brief cross-section of Dr. Shaffer's publications provides a clue to depth of his accomplishments. For example,

1. What Health Services Do School-Age Children Need?
2. Examination and Evaluation of High School Athletes
3. Are Little Leagues Good For Children?
4. School Health Is A Community Undertaking
5. Causation, Prevention and Control of Staphylococcal Diseases in Hospitals
6. The Child in Athletics
7. Health and Activity Needs of the Adolescent

(Continued on Next Page)

DR. RUPPERSBERG

Without a doubt, there are in Ohio today mothers who are living as a direct result of the work of this committee.

Honors have been bestowed on him from groups within and outside the medical profession. He is a retired Colonel in the Ohio National Guard, having served 38 years. Prior to his retirement in 1967, he served as Chief of Staff and State Surgeon for the Ohio Guard. Upon his retirement, he was awarded the Army's Legion of Merit for his medical and administrative work. This award, not usually made during peacetime, was his second Legion of Merit decoration.

In honoring him, we also honor this dedicated committee. You all know to whom I am referring —Dr. Anthony Ruppersberg, Jr.

Tony, I am pleased and honored to award to you, with the admiration and grateful thanks of this association and the medical profession of this great state, the Ohio State Medical Association Distinguished Service Citation.

DR. SHAFFER

8. Preventive Pediatrics
9. Preseason Medical Screening
10. Role of School and Community in Sex Education
11. Health of the Interscholastic Athlete
12. Capillary Microscopy in Juvenile Diabetes Mellitus

Tom is a fellow of the American Academy of Pediatrics, American College of Sports Medicine and American Public Health Association.

In 1964, Tom was presented the William G. Anderson Award by the American Association for Health, Physical Education, and Recreation "in recognition of meritorious service to the profession of health, physical education and recreation."

Dr. Shaffer, I am pleased and honored at this time to award to you, with the admiration and grateful thanks of this Association and the medical profession of this great state, the Ohio State Medical Association Distinguished Service Citation.

★

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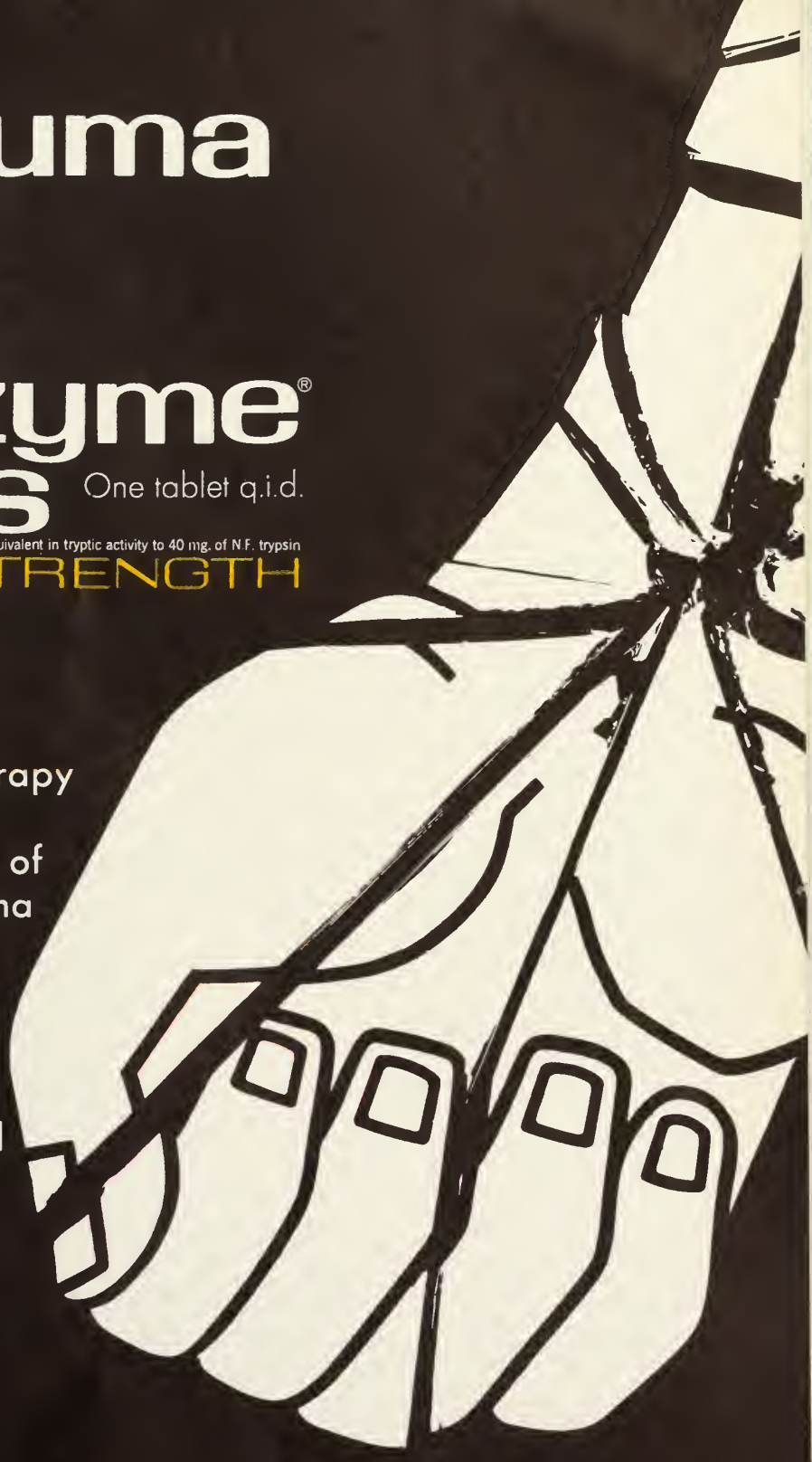
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Annual Meeting Photo Features



Members of the House of Delegates listen intently as the first session gets under way.



Following the awarding of the OSMA Distinguished Service Citation, Dr. Tom Shaffer is interviewed by Paul White of the WBNS-TV Station in Columbus. Mr. White was one of several representatives of the news media who covered features of the Annual Meeting.



Certificates of Humanitarian Service for physicians who served recently under the Volunteer Physicians for Vietnam program sponsored by the AMA were presented before the House of Delegates. From left, are Dr. Joseph H. Gaudreault, Hinckley; Dr. William F. Mitchell, Columbus; and Dr. Jack R. Bontley, Columbus.

Not present were Dr. William R. Brinker, Ravenna; Dr. Robert C. Cahill, Attica; and Dr. John E. Stephens, Columbus, who will receive their certificates at a later date.



Dr. Norman Vincent Peale drives home a point in his dynamic presentation to physicians and guests at the Annual Meeting.

Annual Meeting Photo Features



Robert D. Novak, Washington columnist and author, is shown as he gave the principal address for the Ohio Medical Political Action Committee luncheon, sponsored by OMPAC during the Annual Meeting.



Part of the panel for the discussion entitled "Growing Up with Sex Education," sponsored by the OSMA Committee on School Health, are, from left, Dr. Charles H. McMullen, committee chairman, Walter Knopp, M.D., and Nancy Clatworthy, Ph. D.



The new President-Elect and Eleventh District Councilor demonstrate the art of relaxation by entering into the spirit of the "Far East Fling," Wednesday evening social highlight of the meeting.



Life goes on. This scene was snapped in the back of the room during the session sponsored by the Section on Obstetrics and Gynecology.

Annual Meeting Photo Features



Dr. Nicholas P. Dallis, right, former Toledo practitioner, and creator of "Rex Morgan, M.D.," and other comic page strips, was featured speaker on Tuesday afternoon. He is shown chatting with a friend of long standing, Dr. Paul Orr, of Toledo.



Dr. Fred L. Allman, Jr., of Atlanta, Ga., was one of the participants in the program "The Health Team — for Better Athletics, Better Living" sponsored jointly by the OSMA and the Ohio High School Athletic Association.



High school student members of the Pre-Medical Club of Cuyahoga Falls dismount from their bus outside the Veterans Memorial Building prior to their tour of the exhibit area. The club is sponsored by the Summit County Medical Society with Dr. John A. Karnoupakis as adviser.



Delegates enjoyed a buffet dinner in the Sheraton-Columbus Motor Hotel prior to the opening of the House of Delegates on Monday, May 11.

Annual Meeting Photo Features



Robert Gagel, immediate past president of the OSU Chapter, Student American Medical Association, moderates question-and-answer period during the session sponsored by SAMA.



"A View of the Medical Profession by Today's Medical Students" was the theme discussed by members of this panel on Thursday afternoon in the session sponsored by the Student AMA.



Student AMA members sponsored and manned this booth on the exhibit floor of the Veterans Memorial Building during the Annual Meeting. This scene is typical of the many physician-student powwows at the booth.



Part of the audience as seen during the session sponsored by the Student AMA.

Annual Meeting Photo Features



Dr. Anthony Ruppersberg expresses his appreciation to the House of Delegates after receiving the OSMA Distinguished Service Award.



President Robert N. Smith and Mrs. Gwen Glyer admire painting presented by Dr. James S. Klumpp, of Huntington, W. Va., at the Council dinner honoring Past Presidents.



Dr. Robert E. Zipf, Chairman of the Scientific Works Committee, chats with fellow physicians at the luncheon and orientation session for new members.



AMA Education and Research Foundation checks were presented to representatives of Ohio's four medical schools. Displaying the checks just received are, from left, Dr. Richard L. Meiling, OSU College of Medicine; Dr. Frederick C. Robbins, Case Western Reserve University School of Medicine; Dr. Robert Tidrick, Medical College of Ohio at Toledo; and Dr. Clifford G. Grulee, Jr., University of Cincinnati College of Medicine.

Annual Meeting Photo Features



Dr. Roger O. Egeberg and President Smith stroll through the Exhibit area during the guest speaker's brief visit to Columbus.



Thomas L. Ring, M.D., of Bellaire, President of the Belmont County Medical Society, holds the distinction of being the first physician to participate in the Ohio State Medical Association membership auto leasing plan. Dr. Ring is shown inspecting an auto exhibited by the plan's management at the OSMA 1970 Annual Meeting, held May 11-14 in Columbus. The program was initiated by The Council as a service to OSMA members whereby they may lease any make of auto, and may specify the equipment they want included with the vehicle. Information regarding the plan may be obtained by writing OSMA Membership Auto Leasing Plan at OSMA headquarters.



President of the West Virginia Medical Association, Dr. Maynard P. Pride, brings a good will message to the House of Delegates.

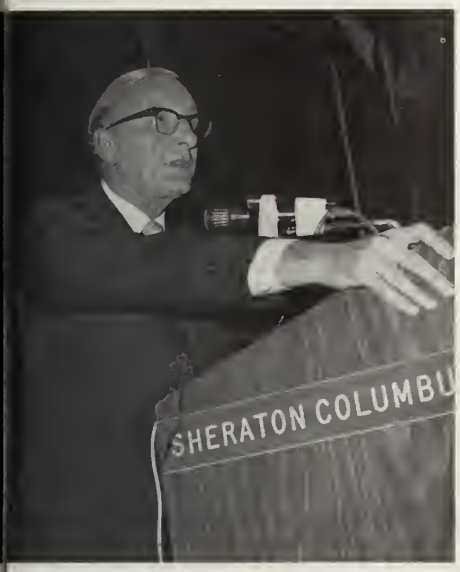


Dr. Clarence B. Nyce, Chairman of Resolutions Committee No. 3 presents the committee's report before the second session of the House of Delegates.



OSU Trainer Ernie Biggs was one of the featured speakers during the presentation entitled, "The Health Team — for Better Athletics, Better Living."

Annual Meeting Photo Features



Dr. Ernest B. Howard, Executive Vice-President of the AMA, is shown as he addressed the OSMA House of Delegates at the first session.



Incoming President Richard L. Fulton and Mrs. Fulton enjoy festivities at the Council dinner honoring Past Presidents.



During his brief stay at the Annual Meeting, Dr. Roger O. Egeberg managed to contact many Ohioans. Shown here, from left, are Sewall Milliken and Frances Williamson, of the Ohio Department of Health; Dr. Egeberg; his host, President Smith; and Dr. H. William Porterfield, past president of the Academy of Medicine of Columbus.

Outstanding Exhibits Recognized at 1970 Annual Meeting

SPECIAL RECOGNITION was given to eight outstanding exhibits after a judging committee reviewed scientific and health education at the 1970 OSMA Annual Meeting, in Columbus. The eight were part of the overall display on the exhibit floor of the Veterans Memorial Building, consisting of some 33 scientific, 18 health education, and 79 technical exhibits.

Sponsors of the outstanding exhibits were presented plaques to be displayed on the respective exhibits and kept as permanent mementos with certificates indicating the various categories of awards authorized by planners of the Annual Meeting.

Following is a brief summary of awards presented. Watch for future issues of *The Journal* and more details on the outstanding exhibits.

Gold Award in Original Investigation: The exhibit, "Venous Autograft Reconstruction for Segmental Coronary Disease," sponsored by the following team from the Cleveland Clinic: Rene G. Favaloro, M.D., Donald B. Effler, M.D., Laurence K. Groves, M.D., F. Mason Sones, Jr., M.D., Earl K. Shirey, M.D., William C. Sheldon, M.D., Mehdi Razavi, M.D., and Robert Quint, M.D.

Gold Award in Teaching: The exhibit, "3 B Micro Anatomy of the Ear," sponsored by David J. Lim, M.D., and W. C. Lane, of the Department of Otolaryngology, Ohio State University College of Medicine.

Silver Award in Original Investigation: The exhibit, "Cutaneous Complications of Immuno Suppressive Therapy," sponsored by the following team from the Cleveland Clinic: Wilma F. Bergfeld, M.D., James G. Ryan, M.D., Henry H. Roenigk, Jr., M.D., S. Nakamoto, M.D., Sharad D. Deodhar, M.D., and Richard R. Evans, M.D.

Silver Award in Teaching: The exhibit, "A Method of Examining Tendons and Nerves in the Hand," sponsored by Robert J. Duran, M.D., Robert G. Houser, M.D., and Richard Mattison, M.D., Ohio State University Hand Clinic, Columbus.

Bronze Award in Original Investigation: The exhibit, "Clinical Complications Following Renal Transplantation," sponsored by Donald G. Vidt, M.D., William Kiser, M.D., and Sharad Deodhar, M.D., of the Cleveland Clinic.

Bronze Award in Teaching: The exhibit, "Cystic Fibrosis—An Obstructive Pulmonary Disease," sponsored by Bernard Boxerbaum, M.D., Carl F. Doershuk, M.D., LeRoy W. Matthews, M.D., Robert C. Stern, M.D., and Susan Pittman, M.D., Case Western Reserve University School of Medicine.

A Special Award was presented to the exhibit, "Four Years Experience in Out-Patient Office Surgery," sponsored by the following members of a Columbus team: John C. Trabue, M.D., John L. Terry, M.D., H. William Porterfield, M.D., and Eugene R. Perrin, M.D.

Honorable Mention was given the health education exhibit, "Utilization Review by Length of Stay," sponsored by James L. Henry, M.D., and the Academy of Medicine of Columbus and Franklin County.

Brain Tumor Symposium Scheduled at Ohio State

A Brain Tumor Symposium, sponsored by the Division of Neurological Surgery, Ohio State University College of Medicine, will be held in the Medical Center, October 5-6.

Recent advances in tissue culture, biochemistry and chemotherapy of brain tumors will be stressed.

Speakers included are Drs. Norman Allen, W. George Bingham, Jr., William E. Hunt, Wolff Kirsch, Adalbert Koestner, Gerard M. Lehrer, Leopold Liss, M. Stephen Mahaley, Jr., David P. Rall, Martin P. Sayers, Edwin C. Shuttleworth, Jr., James Swenberg, F. J. Unterharnscheidt, Wolfgang Wechsler, Charles B. Wilson and David Yashon.

Direct inquiries to W. George Bingham, Jr., M.D., 410 West Tenth Avenue, Columbus 43210.



‘ou can hang on for a few more minutes, Doctor, ı sure I’ll sneeze again.”

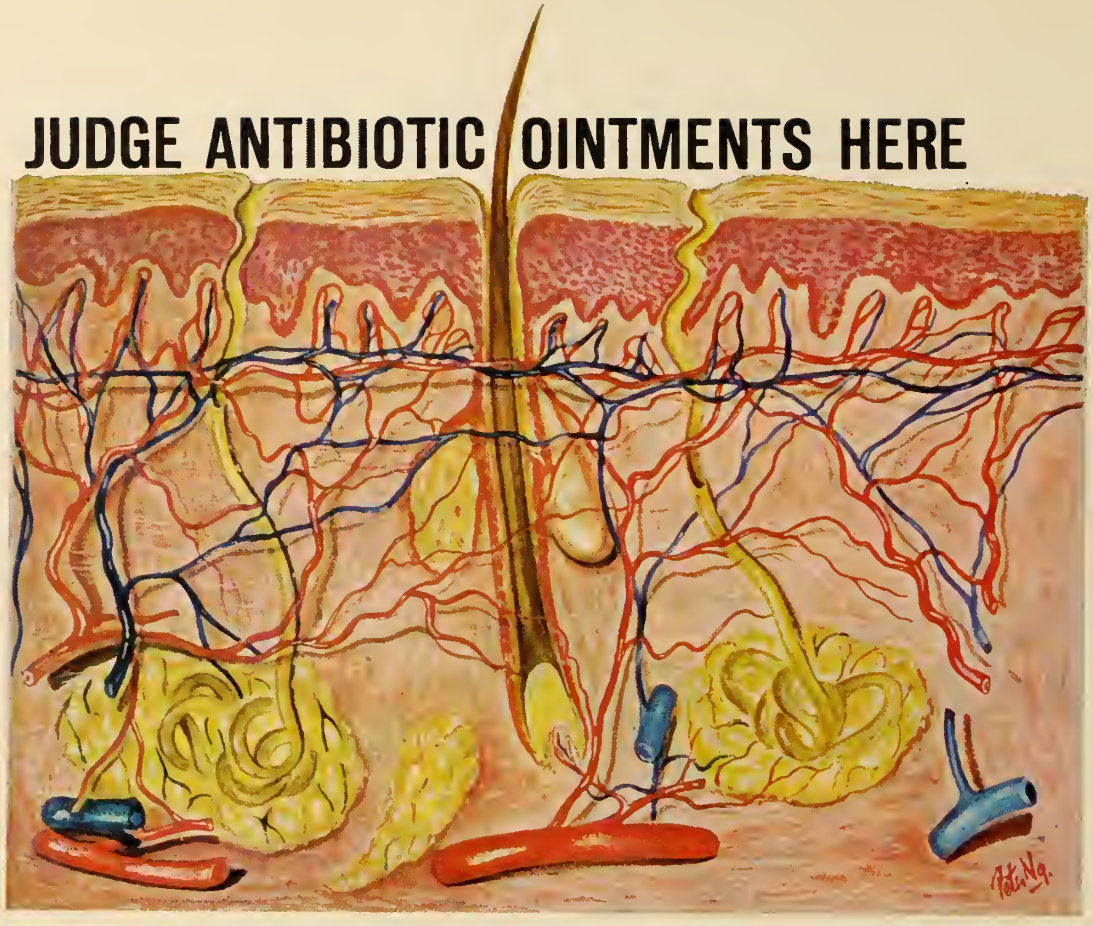
ıeeze. And sneeze some more. But with Novahis- _P, most patients get prompt and long-lasting ‘om the symptoms of allergies and colds. These ıous-release tablets have a vasoconstrictor-anti- ine formulation that begins working in minutes, ontinues to provide relief for hours. Even when congestion is due to repeated allergic episodes, ovahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

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400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically.* (*J. Urol. 73:487-93*)

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between doses rather than lowering the recommended dose is preferable. The prompt direct action allows a cautiousness of the first suggestion of return of symptoms . . . a guide to dose spacing and to determine when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

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For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
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Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

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Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by mid-morning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

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PR-7163

Proceedings of the House of Delegates 1970 Annual Meeting

MINUTES OF FIRST SESSION

THE FIRST SESSION of the House of Delegates of the Ohio State Medical Association was held at 7:00 p.m., Monday, May 11, 1970. The meeting was held at the Sheraton-Columbus Motor Hotel, in Columbus.

The invocation was delivered by Dr. Donald J. Vincent, Columbus, Chairman of the OSMA Committee on Medicine and Religion.

Dr. Philip Taylor, of Columbus, President of the Columbus Academy of Medicine, welcomed the delegates to Columbus.

By unanimous consent, the delegates authorized the use of the "Sturgis Standard Code of Parliamentary Procedure" during the 1970 session of the House.

Dr. Howard Addressed the House

Dr. Ernest B. Howard, Executive Vice-President of the American Medical Association addressed the House.

Report on Delegates Present

Dr. William J. Lewis, Montgomery County, Chairman of the Credentials Committee, reported 156 delegates seated and eligible to vote. A number of alternate-delegates, officers of county medical societies and executive secretaries were in attendance.

1969 Minutes Approved

The minutes of the 1969 sessions of the House of Delegates, as published in the July, 1969, issue of *The Ohio State Medical Journal,* were approved by official action.

Introduction of Guests

Dr. Smith introduced the following honored guests:

Dr. James R. Hull, Columbus, representing the Ohio Dental Association; Sister Grace Marie Hiltz, Cincinnati, President, Ohio Hospital Association; Dr. Eugene DeLucia, Vienna, President, Ohio Osteopathic Association of Physicians and Surgeons; Mr. Dale Cochran, Columbus, President, Ohio State Pharmaceutical Association; Mrs. Wilda Haines, Canton, President, Ohio State Society of Medical Assistants; Mrs. Samuel L. Meltzer, Portsmouth, President, Woman's Auxiliary to the Ohio State Medical Association; Mrs. Carl F. Goll, Steubenville, President-Elect, Woman's Auxiliary to the Ohio State Medical Association; Mr. Charles S. Nelson, Columbus, and Mr. George H. Saville, Columbus, past Executive Secretaries of the Ohio State Medical Association; Mr. Jim Imboden, Columbus, AMA Field Representative; Dr. Mervin F. Steves, Columbus, Executive Secretary of the Ohio State Medical Board, and Dr. Robert E. Zipf, Dayton, Chairman of the OSMA Committee on Scientific Work.

OSMA Past Presidents Introduced

The following Past Presidents of the Association were introduced: Dr. H. M. Clodfelter, Columbus; Dr. Henry A. Crawford, Cleveland; Dr. Robert E. Howard, Cincinnati; Dr. Charles L. Hudson, Cleveland; Dr. Theodore L. Light, Dayton; Dr. Carl A. Lincke, Carrollton; Dr. Robert S. Martin, Zanesville; Dr. Frank H. Mayfield, Cincinnati; Dr. Richard L. Meiling, Columbus; Dr. Lawrence C. Meredith, Oberlin; Dr. Horatio T. Pease, Wadsworth; Dr. George W. Petznick, Cleveland, and Dr. Robert E. Tschantz, Canton.

Also introduced were former members of The Council: Dr. Chester H. Allen, Portsmouth; Dr. Fred P. Berlin, Lima; Dr. Philip B. Hardymon, Columbus; Dr. Frederick T. Merchant, Marion; Dr. Paul N. Orr, Perrysburg; Dr. George N. Spears, Ironton, and Dr. Chester P. Swett, Lancaster.

Report of Woman's Auxiliary President

Mrs. Samuel L. Meltzer, Portsmouth, President of the Woman's Auxiliary to the Ohio State Medical Association, was presented. Mrs. Meltzer reported on Auxiliary activities during her administration.

AMA-ERF Checks Presented

The following representatives of Ohio's medical schools received checks of the American Medical Association Education and Research Foundation from Dr. Philip B. Hardymon, chairman of the Ohio Committee for the American Medical Association's Education and Research Foundation: Dr. Clifford G. Grulee, Jr., Dean of the University of Cincinnati College of Medicine;

Dr. Richard L. Meiling, Dean of The Ohio State University College of Medicine; Dr. Frederick C. Robbins, Dean of Case Western Reserve University of Medicine, and Dr. Robert Tidrick, Professor of Surgery of the Medical College of Ohio at Toledo.

Distinguished Service Citations to Drs. Ruppersberg and Shaffer

Drs. Anthony Ruppersberg, Jr., and Thomas E. Shaffer, both of Columbus, received from Dr. Smith the Distinguished Service Citation in recognition of their outstanding contributions to Ohio medicine. Drs. Ruppersberg and Shaffer addressed the House of Delegates following presentation of the citations. (See pages 708 and 709 for the text of Drs. Ruppersberg's and Shaffer's citations.)

Volunteer Physicians for Vietnam

Under the project Vietnam Volunteer Program, sponsored by the American Medical Association, the following physicians were awarded certificates in recognition of meritorious service performed for the medical profession, the United States Government, and the people of South Vietnam: Dr. Jack R. Bontley, Columbus; Dr. Joseph H. Gaudreault, Hinckley, and Dr. William F. Mitchell, Columbus.

It was indicated that certificates will be presented at county medical society meetings at a later date for the following who were not present: Dr. William R. Brinker, Ravenna; Dr. Robert C. Cahill, Attica, and Dr. John E. Stephens, Columbus.

Council Plaque Presented

A plaque for service on the OSMA Council, including the Presidency, was presented to Dr. Theodore L. Light, Dayton, for service from 1963-1970.

Certificates to Retiring Committeemen

Retiring Committeemen and a retiring AMA Delegate honored were: Dr. Isador Miller, Urbana, member of the Committee on Scientific Work; Dr. Walter J. Zeiter, Cleveland, member of the Committee on Scientific Work; the late Dr. Samuel Marable, Columbus, member of the Committee on Scientific Work (Dr. Philip Taylor, who succeeded him accepted his award on behalf of the Academy of Medicine of Columbus and Franklin County); Dr. James G. Roberts, Akron, Committee on Workmen's Compensation (not present); Dr. Theodore L. Light, Dayton, Ohio Medical Indemnity Liasion Committee member, and Dr. Charles A. Sebastian, Cincinnati, AMA Delegate (not present).

Reference Committees Appointed

The following House of Delegates Reference Committees were appointed by the President:

Credentials of Delegates—William J. Lewis, Montgomery County, Chairman; James T. Stephens, Lorain County; R. A. Gandy, Lucas County; Isador Miller, Champaign County, and Shepard A. Burroughs, Ashtabula County.

President's Address and President-Elect's Address—Roland L. Kennedy, Lucas County, Chairman; James H. Williams, Franklin County; John H. Budd, Cuyahoga County; Edmond K. Yantes, Clinton County, and Adam J. Earney, Holmes County.

Resolutions Committee No. 1—James C. McLarnan, Knox County, Chairman; Robert P. Johnson, Butler County; Frank L. Shively, Jr., Montgomery County; John C. Smithson, Hancock County; Harry C. Mack, Lucas County; Nicholas G. DePiero, Cuyahoga County; G. E. DeCicco, Mahoning County; Robert Johnson, Coshocton County; Robert A. Ringer, Guernsey County; Harry Nenni, Lawrence County, and A. Burney Huff, Wayne County.

Resolutions Committee No. 2—H. William Porterfield, Franklin County, Chairman; William R. Culbertson, Hamilton County; Roger C. Henderson, Greene County; Thomas L. Edwards, Allen County; Wilson Stough, Henry County; Clarence L. Huggins, Jr., Cuyahoga County; E. Gates Morgan, Summit County; Paul N. Mastros, Jefferson County; Kenneth Bennett, Washington County; John Zimmerly, Jackson County; William Graham, Huron County.

Resolutions Committee No. 3—Clarence B. Nyce, Wood County, Chairman; Thomas E. Fox, Warren County; Jerry Hammon, Miami County; Paul E. Lyons, Marion County; Wesley J. Pignolet, Lake County; Mark Herbst, Stark County; Robert E. Rinderknecht, Tuscarawas County; J. R. Wells, Licking County; Thomas W. Morgan, Gallia County; Jasper M. Hedges, Pickaway County, and Richard B. Belt Richland County.

Tellers and Judges of Election—Walter Daniel, Seneca County, Chairman; J. K. Welborn, Lucas County; Dale A. Hudson, Miami County; Kenneth W. Clement, Cuyahoga County; E. W. Cauffield, Summit County, and Frederick W. Dierker, Franklin County.

Nominating Committee Elected

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations:

First District—Harry K. Hines, Hamilton County.

Second District—William M. Porter, Montgomery County.

Third District—Fred P. Berlin, Allen County.

Fourth District—C. Douglass Ford, Lucas County.

Fifth District—Joseph L. Bilton, Cuyahoga County.

Sixth District—William A. White, Jr., Stark County.

Seventh District—Glenn Dowell, Carroll County.

Eighth District—Chester P. Swett, Fairfield County.

Ninth District—Thomas W. Morgan, Gallia County.

Tenth District—Joseph A. Bonta, Franklin County.

Eleventh District—William R. Graham, Huron County.

Dr. Smith then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the committee this year would be the delegate from the Eighth District, Dr. Chester P. Swett, Fairfield County.

President's Address

Mr. Page introduced President Robert N. Smith, Toledo, who delivered his Presidential Address. (Text of the address appears on page 696.)

President-Elect's Address

Dr. Smith introduced President-Elect Richard L. Fulton, Columbus, who delivered his Inaugural Address. (The address appears on page 704.)

State Presidents Introduced

The following state presidents were introduced and addressed the House: Dr. Walter L. Cawood, President, Kentucky Medical Association; Dr. William A. Limberger, President-Elect, Pennsylvania Medical Society; Dr. Maynard P. Pride, President, West Virginia State Medical Association; Dr. Lowell H. Steen, President, Indiana State Medical Association.

Also introduced was: Dr. James S. Klumpp, Huntington, West Virginia, a guest from the West Virginia State Medical Association.

Introduction of Resolutions

Dr. Smith then called for introduction of resolutions. He ruled that resolutions which had been presented within the 60-day time limit and had been distributed to the delegates in advance of the meeting could be read by title only for referral. Twenty resolutions were read by title only and referred to the resolutions committees.

The revised Constitution and Bylaws prepared by a special committee under the specifications of Resolution 3-69, was referred to Resolutions Committee No. 1.

The Malpractice Report, under the authorization of Resolution No. 7-67, was referred to Resolutions Committee No. 2.

New Resolutions Presented

Dr. Smith then called for the presentation of new resolutions. The following resolutions, by consent of two-thirds of the delegates present, were accepted for consideration by the House:

RESOLUTION NO. 21-70

OSMA Positions, Policies, and Responsibilities Regarding Environmental Health
(By the Academy of Medicine of Toledo and Lucas County)

Dr. Smith referred this resolution to Resolutions Committee No. 2.

RESOLUTION NO. 22-70

Great Lakes Water Management Board
(By the Academy of Medicine of Toledo and Lucas County)

Dr. Smith referred this resolution to Resolutions Committee No. 2.

RESOLUTION NO. 23-70

Formation of Medical Task Forces on a National Basis To be Sent Into Areas Where Medical Need is Demonstrated
(By Sol Maggied, M.D., Delegate from Madison County)

Dr. Smith referred this resolution to Resolutions Committee No. 3.

RESOLUTION NO. 24-70

Concerning Proficiency Evaluation in the Physician's Private Office
(By Lawrence J. McCormack, M.D., a Delegate from Cuyahoga County)

Dr. Smith referred this resolution to Resolutions Committee No. 3.

RESOLUTION NO. 25-70

Support of American Medical Association CPT Coding & Nomenclature
(By the Academy of Medicine of Cleveland)

Dr. Smith referred this resolution to Resolutions Committee No. 2.

OMI Honored

Dr. Smith then presented an expression of commendation to Ohio Medical Indemnity, Inc., as follows:

"It is moved that this House of Delegates hereby extend to Ohio Medical Indemnity, Inc. (Blue Shield of Ohio), sincere congratulations and commendation for the achievement of 25 years

of development and expansion of the principles of voluntary medical insurance for the benefit of the citizens of Ohio."

By unanimous consent of the House, the rules were suspended, the resolution was taken up for immediate consideration and **was adopted.**

House Recessed

The House then recessed until the second session, Thursday evening, May 14.

MINUTES OF THE SECOND SESSION

The second business session of the House of Delegates convened at 7:00 p.m., Thursday, May 14, at the Sheraton-Columbus Motor Hotel. A buffet dinner preceded the business session.

Report of AMA Delegation

Dr. John H. Budd, Cleveland, chairman of Ohio's Delegation to the American Medical Association, reported to the House of Delegates on the activities of the Ohio Delegation during the preceding year.

Report of Credentials Committee

Dr. William J. Lewis, Montgomery County, chairman of the Committee on Credentials reported 157 delegates were seated and eligible to vote.

Election of President-Elect

Dr. Smith called for nominations for the office of President-Elect. Dr. Vincent T. LaMaida, Cleveland, placed in nomination the name of Dr. P. John Robechek, Cleveland, Councilor of the Fifth District. The nomination was duly seconded by Dr. Oscar W. Clarke, Gallipolis. Dr. Robechek **was elected by acclamation.**

Election of Councilors

Dr. Chester P. Swett, Fairfield County, as chairman, presented the report of the Nominating Committee. The report follows:

First District

As Councilor of the First District to succeed himself, the committee placed in nomination Dr. Paul N. Ivins, of Hamilton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Ivins was declared reelected Councilor of the First District for a term of two years, 1970-1971 and 1971-1972.**

Third District

As Councilor of the Third District to succeed himself, the committee placed in nomination Dr. Dwight L. Becker, of Lima. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Becker was declared reelected Councilor of the Third District for a term of two years, 1970-1971 and 1971-1972.**

Fifth District

As Councilor of the Fifth District, to succeed Dr. P. John Robechek, Cleveland, the committee placed in nomination Dr. David Fishman, of Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Fishman was declared elected Councilor of the Fifth District for a term of two years, 1970-1971 and 1971-1972.**

Seventh District

As Councilor of the Seventh District to succeed himself, the committee placed in nomination Dr. Sanford Press, of Steubenville. The nominations being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Press was declared reelected Councilor of the Seventh District for a term of two years, 1970-1971 and 1971-1972.**

Ninth District

As Councilor of the Ninth District to succeed himself, the committee placed in nomination Dr. Oscar W. Clarke, of Gallipolis. The nomination being duly seconded and their being no further nominations from the floor, by official action the nominations were closed and **Dr. Clarke was declared reelected Councilor of the Ninth District for a term of two years, 1970-1971 and 1971-1972.**

Eleventh District

As Councilor of the Eleventh District to succeed himself, the committee placed in nomination Dr. William R. Schultz, of Wooster. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Schultz was declared reelected Councilor of the Eleventh District for a term of two years, 1970-1971 and 1971-1972.**

Secretary-Treasurer

For Secretary-Treasurer, the committee placed in nomination Dr. James L. Henry, Grove City, to

succeed himself. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and **Dr. Henry was declared reelected for a term of three years: 1970-1971, 1971-1972 and 1972-1973.**

AMA Delegates

The Nominating Committee then placed in nomination the following for the office of delegate to the American Medical Association for a term of two years beginning January 1, 1971: Drs. Robert E. Howard, Cincinnati; Richard L. Meiling, Columbus; Lawrence C. Meredith, Oberlin; George W. Petznick, Cleveland; Robert N. Smith, Toledo, and Robert E. Tschantz, Canton.

Dr. Smith called for nominations from the floor and there were none. A secret ballot was taken and the **following were elected delegates to the American Medical Association for a term of two years, beginning January 1, 1971: Drs. Meiling, Meredith, Smith and Tschantz.**

AMA Alternate Delegates

For alternate delegates to the American Medical Association for a term of two years beginning January 1, 1971, the Nominating Committee placed in nomination the names of Drs. Dwight L. Becker, Lima; Oscar W. Clarke, Gallipolis; Henry A. Crawford, Cleveland; Jerry Hammon, West Milton; Robert E. Howard, Cincinnati; Elmer R. Maurer, Cincinnati, and H. William Porterfield, Columbus. Dr. Smith called for nominations from the floor and there were none. A secret ballot was taken and the **following were elected alternate-delegates to the American Medical Association for a term of two years beginning January 1, 1971: Drs. Becker, Clarke, Crawford and Porterfield.**

Nominations were then declared in order to fill two vacancies among the alternate delegates to the American Medical Association for terms beginning January 1, 1971 and ending December 31, 1971. The following were nominated for these vacancies: Drs. Robert R. Clark, Akron; George N. Bates, Toledo; Lawrence J. McCormack, Cleveland; Elmer R. Maurer, Cincinnati; Robert E. Howard, Cincinnati, and Jerry Hammon, West Milton. **Dr. Hammon was declared elected on the second ballot and Dr. Bates was declared elected following the fourth ballot.**

Committee on President's Address

Dr. Smith then called for the report of the Reference Committee on President's Address, which was presented by Dr. Roland L. Kennedy, Lucas County, chairman of the committee. The report read as follows:

"The President's address impressed the Committee as another example of Dr. Smith's effective leadership as he reviewed the many activities of the Association during the year. 'One of the best Presidential addresses ever given' was the opinion of many of the delegates. It was a progress report on many of the programs that Dr. Smith instituted in his address as President-Elect one year ago.

"Dr. Smith warned that the 'fundamental values in all areas, which were absolute a few years ago, are being challenged,' which verbalized so well what is the concern of all of us. There were no laments, no cries for sympathy, but a sense of concreteness whereby Dr. Smith identified many of our problems with positive programs for their solutions.

"High on Dr. Smith's priorities was the development of the Commission on Medical Education. He was concerned with effecting a closer relationship with the academic community to show that the academician and the practicing physician are not separated into 'ivory towers' and 'bank vaults.' All of us are concerned with the manpower shortage, both medical and paramedical, and Dr. Smith has brought all the appropriate resources of the Association into the Commission. We enthusiastically support his recommendation of a 'buddy system' between local physicians and medical students.

"The continual challenge of comparing the costs of medical care to government statistics, i.e., the Consumer Price Index, is being countered by another of President Smith's innovations, the Department of Economic Research. Besides the employment of its services in legislative testimony, our members will now have comparable statistics concerning their services. Valid conclusions based on in-depth analysis will be available toward solidifying the defense of our policies.

"Better communication for a more effective organization was another basic theme of the President. Public speaking courses and a new format for *The Journal* are positive actions with positive results. There is a closer liaison with specialty groups. Renewed liaison with the Ohio Hospital Association resulted in approval of physicians serving on hospital governing boards. We were admonished, however, to keep all channels of communication open with medical students.

"Dr. Smith emphasized the need of our professional activities to be judged and reviewed by colleagues rather than government or third party groups—peer review. Although distasteful, it is a necessity requiring new and effective means.

"The Committee calls attention to other items of accomplishments reported by the Presi-

dent. The Membership Planning Committee for the 70's is a reality. The survey has been accomplished and the results analyzed for future action.

"Dr. Smith made the following recommendations concerning the Presidency:

1. That the President receive a salary so that any qualified physician will have the opportunity to serve.

2. That the term of office be extended from one to two years, or that the President be eligible to run for reelection for one additional term.

"The Committee endorsed these recommendations and refers them to Council for study. In addition, the Committee recommends that the Council propose a resolution to the American Medical Association that a management training course, as suggested by Dr. Smith, be developed by the AMA to utilize the valuable experience obtained by retiring state presidents.

"The Committee was deeply impressed with Dr. Smith's 'hello-good-by' conclusion.

"I wish to thank the members of my Committee for their appraisal of these addresses and they are: James H. Williams, Franklin County; John H. Budd, Cuyahoga County; Edmond K. Yantes, Clinton County; Adam J. Earney, Holmes County, and Roland L. Kennedy, Lucas County, Chairman."

On a motion made and seconded, the House of Delegates, by official action, approved the report of the Reference Committee on President's Address.

Committee on President-Elect's Inaugural Address

Dr. Smith then called for the report of the Reference Committee on President-Elect's Inaugural Address. The text of the report read as follows:

"The procedural change begun last year, that the President-Elect's address be given during the First Business Session of the House of Delegates, was followed this year by Dr. Fulton. The address sets a climate over the proceedings of the Annual Meeting to which the delegates can set their tack. We recommend its continuation.

"The President-Elect in his address painted a picture of the medical scene as he sees it. He envisioned clouds over the horizon which represent government programs. Besides Medicare and Medicaid, he painted a dark cloud representing a national health insurance program. He saw this cloud materialize supported by irresponsible politicians who are anxious for a program without considering a means to its end. This cloud was augmented by such programs as the recent 'Health In America' series on the Columbia Broadcasting System for which medical consultation was rejected. Two other clouds representing the Regional Medical Program (RMP) and the Comprehensive Health Planning (CHP) have been formed with a probable coalescence resulting in a surviving comprehensive health care program.

"Dr. Fulton recognizes the ultimate good of these programs if they develop as intended. He made reference to a well run Ohio program, but points out the necessity of providing good leadership and management. He did not call for repeal, but rather watchful wariness.

"Prominently displayed in this picture is a big dollar sign representing astronomical settlements of professional liability suits. A comparison was made in this area between the United States and Canada.

1. He noted that the contingency fee is illegal and unethical in Canada.

2. The profession has their own Medical Protective Association which sets no limits on claims, and pays for the defense of a physician for $35.00 a year.

'Doubting Thomases' who wish specific insurance protection, may obtain it at minimal rates.

The trial is not by a jury, but a single judge who may have a professional medical counsel.

"No recommendations were offered because the obvious solutions have already been explored. The Committee urges the OSMA to continue a diligent effort in this area with the highest priority.

"Dr. Fulton directed attention with a sense of urgency to a haze in the painting representing drug abuse. He recommends 'the drug user should be able to seek professional help with complete confidentiality and without fear of prosecution—and we as physicians should be able to deliver that care without fear of prosecution.' We of the Committee endorse this recommendation.

"A dirty smudge on the painting represents pollution about which Dr. Fulton is deeply concerned.

"A multitude of faces appearing in the painting represent the medical students of today. He commended them for their motivation and education, but charged that they continue this motivation even into later years of practice; this will be the ultimate test of their sincerity. The students were admonished to work within the rules, and if the rules need changing it should be done within the existing system.

"Particularly in rural areas, the shortage of physicians in family practice was noted. Because of the poor attendance at the Rural Health

Committee programs, which attempted to interest junior medical students in family practice, Dr. Fulton made the following recommendations:

1. That the format of the annual conference be changed.

2. Encourage the inclusion in the medical schools' curriculum of material previously contained in the Rural Health Committee program.

3. A liaison committee with the four Ohio Medical Schools' SAMA Chapters.

a. An OSMA Councilor responsible for each Chapter

b. Frequent meetings with each Chapter

c. A report of the meeting by the Councilor to the Council

d. A standing invitation to SAMA to meet with the Council.

"The Committee endorses these recommendations.

"Emphasis is directed to a table around which physicians are seated labeled 'peer review committee.' Dr. Fulton properly prefers that those at the table remain physicians.

"Dr. Fulton emphasized his concern about medical manpower with a new path on his landscape. He noted that physicians' assistants may provide a 'tremendous potential' in distribution of our services. He alludes to a resource not fully developed—that of the Navy corpsman. The weary family practitioner may be helped by this new resource.

"Emergency medicine points to a new relation of physicians with hospitals, and Dr. Fulton reminds us that we should work closely with the hospitals.

"Support for the Committee on Athletic Injuries under Dr. Sol Maggied is considered a 'must.'

" 'Together We Care—and We Do' is the title Dr. Fulton has given to his medical painting. Even though there are dark clouds on the horizon, Dr. Fulton is not discouraged and paints an orange sun that penetrates each aspect of the picture.

"I wish to thank the members of my Committee for their appraisal of these addresses, and they are: James H. Williams, Franklin County; John H. Budd, Cuyahoga County; Edmond K. Yantes, Clinton County; Adam J. Earney, Holmes County, and Roland L. Kennedy, Lucas County, Chairman."

On a motion made and seconded, the House of Delegates, by official action, approved the report on the Inaugural Address of the President-Elect.

(See pages 696 and 704 for the addresses of President Smith and President-Elect Fulton.)

Report of Resolutions Committee No. 1

Dr. James C. McLarnan, Knox County, reported for Resolutions Committee No. 1, of which he was chairman. The report read as follows:

"Resolutions Committee No. 1 was directed to hear testimony on three items . . . first, the revised Constitution and Bylaws; second, Resolution No. 1-70, and thirdly, Resolution No. 6-70.

"Rather than repeating the proposed revisions to the Constitution and Bylaws in their entirety, the Committee's report will deal entirely with amendments to the published revisions which have been furnished to each Delegate. (Published beginning on page 290 of the March issue and page 426-A of the April issue of *The Ohio State Medical Journal.)*

"In the Constitution, Article I, Section 2, 'Purposes' subparagraph (7), the Committee felt that the second clause in this subparagraph was unnecessary and redundant. The corrected paragraph will then read, '(7) To carry on such functions and activities as are deemed necessary or desirable to effectuate the above purposes.' It was also felt by the Committee that subparagraphs 7 and 8 should be in reverse order.

"In Article XI, Section 1, 'Method of Amending,' the Committee feels that an alternate method of notification should be provided. The Committee suggested the final clause read, 'provided, however, that such proposed amendment should be published in The Journal of this Association, or sent by first-class mail to all members of the Association, at least sixty (60) days before such meeting and that a true and correct copy thereof shall have been sent officially to the secretary of each component society at least thirty (30) days before each meeting."

On a motion made and seconded, the House of Delegates, by official action, approved the amendments to the proposed revised Constitution and adopted the revised Constitution of the Ohio State Medical Association, as amended, a two-thirds affirmative vote being necessary for approval.

"The Committee next heard testimony concerning the proposed revisions to the Bylaws.

"Under Chapter 1, Section 2, subparagraph (d), it was felt that some provision was necessary to set forth how these members are to be elected and the Committee submits the following amendment.

"In line 6, after the word 'membership' add the phrase 'by their component society.'

"Under Chapter 1, Section 3, 'Eligibility' the Committee felt that the second paragraph of subparagraph (b) was awkward and felt that the purpose of this could best be expressed by amending the first paragraph of Section 3, to read as follows: 'To be eligible for any class of member-

ship other than honorary, or resident and intern, in this Association, a person shall possess all of the following qualifications, to wit: . . .' and deleting the second paragraph of subparagraph (b).

"The Committee recommends amendment of the first paragraph of subparagraph (b) by inserting at the end of the second line, 'or osteopathic medicine and surgery.'

"In Chapter 1, Section 5, 'Effect of Expiration, Revocation, or Termination of Certificate' the Committee expressed concern that membership would be denied to members who have retired and who have elected not to renew their state board registration. The Committee recommends the wording to read as follows: 'Membership in this Association of a member **in active practice** whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be canceled automatically as of the effective date of such expiration, revocation or termination. The provisions of this Section 5 shall not apply to members who have retired from active practice.'

"Chapter 3, Section 9, 'Papers the Property of the Association,' There was concern stated before the Committee that these papers should not be permanently held by the Editor of The Journal unless he intends to publish them at a later date. To alleviate this concern, the Committee felt that a sentence should be added at the end of this section to read, 'These papers shall be released to the author by the Editor of The Journal if he has not stated, within a period of six (6) months after submission, his intent to publish them.'

"In Chapter 4, Section 1, the Committee felt the clarity of the Bylaws could be improved by deleting the last sentence of Section 3 and adding it to Section 1, as an additional sentence. Section 1 would then read, 'The House of Delegates shall meet annually at the time and place of the Annual Meeting of this Association. All sessions of the House of Delegates shall be open to all members in good standing of this Association.'

"Under Section 2, of Chapter 4, 'Ratio of Representation' the Committee feels that the clarity of the second paragraph would be improved if the first clause were reworded as follows: 'In case a delegate or alternate delegate of a component society is unable to serve, . . .'

"Chapter 4, Section 6, 'Councilor Districts' the Committee felt that the second paragraph was obsolete and recommends its deletion.

"Under Chapter 5, the Committee felt continuity would be better maintained by reversing the order of Section 5 and Section 6.

"The Committee next considered Chapter 6 and suggested the title to be changed to read, 'Duties and Terms of Officers and the Executive Director.'

"Under Section 2, of Chapter 6, the Committee recommends the insertion of the word 'temporary' before the word 'absence' at the end of line 6. This sentence now reads, 'He shall assume the duties of the President during the temporary absence or disability of the latter.'

"In the interest of continuity, the Committee suggests that the present Section 5 be advanced to become Section 3, and Section 3 thus becomes Section 4, and Section 4 becomes Section 5.

"The Committee next discussed the title of Chapter 10, Section 2, 'Charters of Societies.' It was felt that the body of the section could best be expressed by changing the title to read, 'Suspension or Revocation of Charters of Societies.'

"Under Section 10, of Chapter 10, 'Certification of Delegates of Component Societies' the Committee recommends the word 'may' in the last line be changed to read 'shall.'

"Under Section 5, of Chapter 11, entitled 'Appeals' the last paragraph could be improved by adding the word 'upon' in the third line between the words 'and' and 'the,' the line now reading 'the society with the Council and upon the briefs and oral . . .'

"In Chapter 11, Section 7, a typesetting error could be corrected by changing Chapter 1 to Chapter 11, in line 3.

"In Section 8, of Chapter 11, add the sentence 'The provisions of this section do not apply to members who have retired from active practice.'

"Under Chapter 13, 'Rules of Procedure' the Committee recommends the addition of the word 'current' in the third line, the Chapter to now read: 'The deliberations of this Association shall be conducted in accordance with parliamentary usage as prescribed by the current edition of *Sturgis' Standard Code of Parliamentary Procedure,* by Alice Sturgis.

On a motion made and seconded, the House of Delegates, by official action, approved the amendments to the proposed revised Bylaws and adopted the revised Bylaws of the Ohio State Medical Association, as amended.

RESOLUTION NO. 1-70

OSMA Membership for Doctors of Osteopathic Medicine and Surgery

(By the Academy of Medicine of Cleveland)

"During the course of the discussion of the proposed revisions, discussion was held concerning Resolution No. 1-70, 'OSMA Membership for Doctors of Osteopathic Medicine and Surgery,' submitted by the Academy of Medicine of Cleveland. In the opinion of the Committee, the deletion, in the proposed revision, of the qualification for membership of the necessity of holding the degree of doctor of medicine effectively accomplished the purpose of this resolution, as the qualifications now require that a member hold a certificate to practice medicine and surgery, or os-

teopathic medicine and surgery. Since the purpose of this resolution has already been accomplished, the Committee feels that Resolution No. 1-70, as such, be not approved."

By official action, Resolution No. 1-70 was NOT adopted. This action was in accordance with the recommendation of the Resolutions Committee.

RESOLUTION NO. 6-70

Automatic Expulsion of Ohio State Medical Association Members Who Do Not Complete Citizenship Within A Period of Five Years
(By the Academy of Medicine of Cincinnati)

"The Committee also discussed Resolution No. 6-70, 'Automatic Expulsion of Ohio State Medical Association Members Who Do Not Complete Citizenship Within A Period of Five Years,' submitted by the Academy of Medicine of Cincinnati. This resolution called for studies to determine the effect of the Bylaw provisions expelling members who do not complete citizenship. The Committee feels that such study has merit and recommends the resolution be adopted."

By official action, a motion to accept the recommendation of the Committee, namely, that Resolution No. 6-70 be adopted, was carried.

"There was considerable discussion concerning the establishment of the office of Speaker of the House of Delegates. The Committee feels it did not have enough information made available to it to make a definite recommendation as a part of the Bylaws and requests that a study be made, by an appropriate committee of the Ohio State Medical Association, concerning the establishment of this office, its advantages and its disadvantages. The Committee also requests a report of this study be made to the House of Delegates at its next Annual Meeting."

The House of Delegates also approved the recommendation of Resolutions Committee No. 1, that a study be made by an appropriate committee concerning the advantages and disadvantages of the establishment of a Speaker of the House of Delegates.

"The Members of Resolutions Committee No. 1 included: Robert P. Johnson, Butler County; Frank L. Shively, Jr., Montgomery County; John C. Smithson, Hancock County; Harry C. Mack, Lucas County; Nicholas G. DePiero, Cuyahoga County; G. E. DeCicco, Mahoning County; Robert Johnson, Coshocton County; Robert A. Ringer, Guernsey County; Harry Nenni, Lawrence County; A. Burney Huff, Wayne County; James C. McLarnan, Knox County, Chairman."

By official action, the report of Resolutions Committee No. 1 as a whole, as amended, was approved by the House of Delegates.

Report of Resolutions Committee No. 2

Dr. H. William Porterfield, Franklin County, reported for Resolutions Committee No. 2, of which he was chairman. The report read as follows:

"Resolutions Committee No. 2 considered 12 resolutions submitted to this House of Delegates as well as Progress Report No. 3 on Substitute Resolution No. 7, entitled 'Group Malpractice Coverage' from the 1967 session.

RESOLUTIONS NOS. 3-, 13-, AND 18-70

"Resolutions No. 3 (submitted by the Academy of Medicine of Cincinnati), 13 (submitted by the Madison County Medical Society), and 18 (submitted by the Academy of Medicine of Columbus and Franklin County), were considered jointly because of similar character.

"The committee hereby submits Substitute Resolution No. 3:

SUBSTITUTE RESOLUTION NO. 3-70

Usual, Customary and Reasonable

WHEREAS, Confusion exists over terminology relating to the methods of determining physicians' fees as defined by third parties, and

WHEREAS, 'Usual, customary and reasonable' has been previously defined by this House in 1966, as follows:

Usual—the 'usual' fee is that fee usually charged for a specific service provided by an individual physician for his patient.

Customary—a fee is 'customary' when it properly reflects the extent and nature of the service provided the patient.

Reasonable—a fee is 'reasonable' when it meets the 'usual, and customary' criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration, and

WHEREAS, A 'prevailing' fee is usually interpreted as representing a median or average fee for a given service, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association reaffirm the 1966 position of the House of Delegates and the October 1969 statement of the Council in support of the 'usual, customary and reasonable' individual physicians' fee, recognizing that these pronouncements include all the factors involved in the determination of the amount of benefits payable for services rendered by a physician; and any other terminology results in confusion and is to be discouraged.

By official action, a motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 3-70 be adopted, was carried.

AMENDED RESOLUTION NO. 7-70

Outpatient Coverage by Ohio Medical Indemnity, Inc. (Blue Shield) in The Office of Physicians in Private Practice

WHEREAS, The Ohio State Medical Association is obligated to seek methods of improving medical services, and

WHEREAS, Patients are demanding coverage for out of hospital services, and

WHEREAS, The physician's office can be used efficiently and economically for such services, THEREFORE, BE IT

RESOLVED, That this House of Delegates encourage the Ohio Medical Indemnity, Inc. to develop plans for expanded medical care programs, including the provision of benefits for medical services rendered outside the hospital, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association lend its assistance and cooperation to OMI in the development of such plans.

By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 7-70 be adopted, was carried.

"Mr. President, Resolution No. 13 as submitted has been combined in Substitute Resolution No. 3."

AMENDED RESOLUTION NO. 14-70

Vital Statistics
(By the Stark County Medical Society)

WHEREAS, The published infant mortality statistics of the World Health Organization give the impression that the United States ranks quite low in these figures, and

WHEREAS, These statistics are widely quoted and tend to discredit physicians, and

WHEREAS, There is no validity in these statistics, inasmuch as items being compared are not comparable, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Council and Staff be requested to distribute existing information and point out the fallacies to the membership and to the news media, and BE IT FURTHER

RESOLVED, That the American Medical Association be urged to develop a method of compiling accurate and comparable statistics.

RESOLVED, That a copy of this resolution be sent to Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, of the Department of Health, Education, and Welfare.

The resolution was amended by the addition of a "Resolved, That a copy of this resolution be sent to Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, of the Department of Health, Education, and Welfare." **By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 14-70 be adopted, as amended, was carried.**

AMENDED RESOLUTION NO. 15-70

Support for Budd Report
(By the Stark County Medical Society)

WHEREAS, As pointed out by the Minority Report following the Report of the Committee on Planning and Development of the American Medical Association, as submitted by Dr. John H. Budd, the Majority Committee Report does not, in certain areas, reflect the feeling of the Ohio State Medical Association, THEREFORE, BE IT

RESOLVED, That this House of Delegates support the recommendation of Dr. John H. Budd's Minority Report wherein he urges 'that precipitate action be avoided,' and BE IT FURTHER

RESOLVED, That the Delegates to the American Medical Association be instructed to seek modification of the Majority Report as outlined in the Budd Report, and BE IT FURTHER

RESOLVED, That, following the action of the Annual AMA meeting in June 1970, the Ohio State Medical Association president be requested to appoint a special committee to carefully study the report of the Committee on Planning and Development and submit its findings to the Council and this House.

By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 15-70 be adopted, was carried.

AMENDED RESOLUTION NO. 16-70

Clarification of Terms
(By the Stark County Medical Society)

WHEREAS, The American Medical Association Resolution No. 10, entitled 'Proper Terminology—'Medical Care' and 'Health Care,' as passed at the November 1969 meeting of the American Medical Association, clearly defines 'medical care' and 'health care' as follows:

> 'Whereas, Good health has been defined by the World Health Organization as a state of total physical, mental and social well being, and not merely the absence of disease; and
>
> 'Whereas, The various news media and agencies of the federal government routinely blame the medical profession for the rising costs of health care; and
>
> 'Whereas, The medical profession can in no significant way control the costs of health care as defined above, but only some aspects of the costs of medical care; and
>
> 'Whereas, Some physicians and even the publications of the American Medical Association (*PR Doctor,* September-October 1969) when speaking of the problems and responsibilities of the medical profession use the erroneous expression health care when they should use the correct term medical care; therefore be it
>
> '**Resolved,** That the House of Delegates instruct the Board of Trustees to initiate at once remedial measures to clarify the meaning of the expressions 'medical care' and 'health care' and to assure their correct usage in all official publications of the American Medical Association; and be it further
>
> '**Resolved,** That such action be a continuing one under the direction of the Executive Vice President designed to correct the terminology of the lay press and enlighten the understanding of the public.'

THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association endorse and support this AMA resolution, and BE IT FURTHER

RESOLVED, That it recommends its implementation on the state and local level.

By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 16-70 be adopted, was carried.

AMENDED RESOLUTION NO. 17-70

The Private Physician and Closed Panel Medical Care
(By the Butler County Medical Society)

WHEREAS, There are laudable and strongly sponsored attempts in Ohio to explore means of improving delivery of medical services at less cost by various systems, including Closed Panel, and

WHEREAS, The Ohio State Medical Association feels that it is essential to high quality medical care that the patient retain the right of free choice of physician, THEREFORE, BE IT

RESOLVED, That the patient retain his right for the free choice of his physician, and BE IT FURTHER

RESOLVED, That high quality medical care be the prerequisite of any medical care system developed, and BE IT FURTHER

RESOLVED, That all systems for the delivery of medical care be explored by the Ohio State Medical Association, and BE IT FURTHER

RESOLVED, That communication be fostered between the Ohio State Medical Association, labor, management and intermediaries to arrive at competitive systems for the continuing delivery of high quality medical services.

By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 17-70 be adopted, as amended, was carried.

"Mr. President, Resolution No. 18 as submitted has been combined in Substitute Resolution No. 3."

RESOLUTION NO. 19-70

Salaried Hospital Based Physicians
(By the Academy of Medicine of Columbus and Franklin County)

"Mr. President, in that Resolution No. 19 refers to problems of ethics, the committee calls attention to the Constitution and Bylaws of the Ohio Sate Medical Association, Chapter 4, Section 4, which states that resolutions of an ethical nature involving professional relations shall be referred to the Council without discussion."

By official action, a motion to accept the recommendations of the committee, namely, that Resolution No. 19-70 be referred to the Council, was carried.

EMERGENCY RESOLUTIONS NO. 21 AND 22

"Resolutions No. 21 and 22, submitted by the Academy of Medicine of Toledo and Lucas County, have been considered jointly because of their common interest, and the committee submits Amended Resolution No. 21 as follows:"

AMENDED RESOLUTION NO. 21

Great Lakes Pollution

WHEREAS, The Great Lakes Basin represents 25 percent of the world's fresh water with only 0.6 percent of the world's population, and

WHEREAS, This basic resource of the urban and industrial heartland of North America is in jeopardy for reason of neglect and mismanagement with lethal implications to our civilization, and

WHEREAS, The Governor of the State of Ohio restricted commercial fishing on some species of fish in the Ohio waters of Lake Erie due to mercury contamination, and

WHEREAS, There is a clear and present public health danger in the pollution of the environment of our State, and

WHEREAS, Matters of public health are the proper concern of the Ohio State Medical Association, and

WHEREAS, The Boundary Waters Treaty of 1909, presently in effect, includes the lakes and rivers along which the international boundary passes but does not include tributaries comprising the total Great Lakes Basin, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association endorse the action of our Governor in the case of Lake Erie, and BE IT FURTHER

RESOLVED, That the Council of the Ohio State Medical Association direct the Committee on Environmental and Public Health to furnish to the Council for publication to the membership pertinent information on:

(A) The adverse health effects of various common pollutants, including known scientific data regarding quantity and degree of hazard.

(B) Needed implementation of existing legislation.

(C) Needed new legislation.

(D) Recommendations for Association policy positions on matters pertaining to pollution and its effects,

and BE IT FURTHER

RESOLVED, That the component societies of the Ohio State Medical Association and their individual members be encouraged to support and stimulate these efforts directed towards control of pollutants in their area particularly in support of existing regulations, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association endorse the formation, with all possible speed, of an international body with appropriate regulatory powers for the control of all biological, chemical, and physical pollutants throughout the Great Lakes drainage basin.

By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 21-70 be adopted, was carried.

EMERGENCY RESOLUTION NO. 25-70

"The committee recommends the adoption of Emergency Resolution No. 25 as submitted."

EMERGENCY RESOLUTION 25-70

Support of American Medical Association CPT Coding & Nomenclature
(By the Academy of Medicine of Cleveland)

WHEREAS, The need for a uniform system of coding and nomenclature in order to describe accurately the great variety of medical services has never been greater, and

WHEREAS, The American Medical Association has prepared an accurate and current system of coding and nomenclature, and

WHEREAS, State medical associations, specialty societies, and others have delayed their own efforts so as to be certain there would be one universal system of description of professional services, THEREFORE, BE IT

RESOLVED, That this House support the 5 digit system of coding and nomenclature of the American Medical Association, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association House of Delegates urge Ohio Medical Indemnity, Medical Mutual of Cleveland and all private insurance carriers to adopt the AMA system of coding and nomenclature as the universal system for description of medical services.

By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 25-70 be adopted, was carried.

PROGRESS REPORT NO. 3 ON SUBSTITUTE RESOLUTION NO. 7-67

Group Malpractice Coverage

"The committee commends the study committee for its outstanding efforts in evaluating a most difficult situation.

"We move the acceptance of the committee report and recommend that continuing efforts be carried out to resolve this difficult problem."

SUBSTITUTE RESOLUTION NO. 7-67

Group Malpractice Coverage

WHEREAS, This House of Delegates recognizes the increasing difficulty of some of its members in obtaining adequate professional liability insurance NOW, THEREFORE, BE IT

RESOLVED, That the House of Delegates requests The Council of the Ohio State Medical Association to investigate the feasibility of group liability insurance for members of the Ohio State Medical Association, AND BE IT FURTHER

RESOLVED, That a progress report be presented at the 1968 Annual Meeting.

Progress Reports were made by the OSMA Council, to the 1968 and 1969 OSMA House of Delegates.

The Progress Report submitted in 1969 was concluded with the statement that the Committee on Insurance would meet after the 1969 Annual Meeting to hear the Medical Protective Company presentation, (and make a final recommendation).

The Committee on Insurance met on June 29, 1969. After detailed consideration of the items listed below, the Committee recommended to the Council that OSMA not sponsor a Professional Liability Insurance plan for its members. (The Council accepted the Committee's recommendation on August 3, 1969)

1. The State Medical Associations in Texas, Michigan and Pennsylvania have recently decided not to sponsor professional liability insurance for their members.

2. Some State Medical Association sponsored plans have experienced difficulty e.g. Oregon and Oklahoma.

3. California, New York and Florida have sponsored plans and the premiums for professional liability insurance in those states are among the highest in the nation.

4. Sponsoring a particular company usually causes minority insurance carriers to stop selling insurance and thereby decreases the available market. Examples in Florida, California and New York were cited.

5. Sponsoring a plan would cause major and minor insurance carriers to reject 'marginal risks' which would cause the sponsored plan to be overloaded with 'marginal risks' and violate a basic principle of insurance which is to obtain a very broad base of 'good and marginal risks.'

6. Major and minor insurers have years of experience in Ohio concerning legal attitude and climate, as well as, public attitude and climate. The company considered as a sponsor of a possible OSMA plan does not have this experience, since it does not presently sell professional liability insurance in Ohio.

7. It is acknowledged that problems do exist in the area of Professional Liability Insurance as it relates to rates, availability, legal climate and public opinion but a state sponsored plan does not necessarily solve these problems.

8. The Medical Protective Company is unalterably opposed to state sponsored programs and if OSMA sponsors a plan, The Medical Protective Company would refuse to be the sponsoring insurance company.

9. A sponsored plan would not and should not provide insurance for 'uninsurable or substandard risks.'

10. The Medical Protective Company currently insures approximately 60 percent of the physicians in the State of Ohio. Buckeye Union and Aetna are the primary minority carriers.

11. The Medical Protective Company currently agrees that it will insure applicants without regard to locality, age or type of practice.

12. The Medical Protective Company will continue to underwrite each applicant with regard to moral character, training as relates to type of practice, previous professional liability suits and other logical underwriting factors.

13. The Medical Protective Company proposes to meet with the Ohio State Medical Association Committee on Insurance periodically to establish and maintain effective communication concerning complaints, premium changes, suits and other matters of mutual concern.

Future Plans

A. The possibility of educational workshops

on professional liability problems is being investigated jointly with the Ohio Hospital Association and Osteopathic Association.

B. The possibility of a state legislative program designed to provide a more efficient and equitable determination of professional liability claims and litigation is being studied. The next 'regular' session of the Ohio General Assembly will convene January 1, 1971.

This Report was approved by the OSMA Council on April 18, 1970.

By official action, a motion to accept the recommendation of the committee, namely, to accept the committee report on Group Malpractice Coverage and to recommend that continuing efforts be carried out to resolve this difficult problem, was carried.

"The report of Resolutions Committee No. 2 is respectfully submitted by the following members: William R. Culbertson, Hamilton County; Roger C. Henderson, Greene County; Thomas L. Edwards, Allen County; Wilson Stough, Henry County; Clarence L. Huggins, Jr., Cuyahoga County; E. Gates Morgan, Summit County; Paul N. Mastros, Jefferson County; Kenneth Bennett, Washington County; John Zimmerly, Jackson County; William Graham, Huron County; H. Wm. Porterfield, Franklin County, Chairman."

By official action, the report of Resolutions Committee No. 2 as a whole, as amended, was approved by the House of Delegates.

Report of Resolutions Committee No. 3

Dr. Clarence B. Nyce, Wood County, reported for Resolutions Committee No. 3, of which he was chairman. The report is as follows:

"Resolutions Committee No. 3 held hearings on eleven resolutions, two of which were emergency resolutions submitted at the first session of the House of Delegates and admitted through a two-thirds vote of those present."

EMERGENCY RESOLUTION NO. 23-70

Concerned with the Formation of Medical Task Forces on a National Basis to be Sent Into Areas Where Medical Need is Demonstrated
(By Sol Maggied, M.D., a Delegate from Madison County)

"After lengthy discussion, the Committee thought that the resolution was a short-term measure and did not sufficiently identify the needs. It also questioned the fact that the proposed task forces were to be conducted on a national rather than state basis. The Committee is, however, in sympathy with the needs for medical care both on a short-term and long-term basis, and therefore urges that an in depth study be made by Council to determine the needs and further urges that the various health agencies and members of the Ohio State Medical Association work through the OSMA, AMA and the Vista-Volunteers already in existence. It therefore recommends that Emergency Resolution 23-70 not be adopted."

By official action, Resolution No. 23-70 was not adopted. This was in accord with the recommendations of the Resolutions Committee.

AMENDED EMERGENCY RESOLUTION NO. 24-70

Concerning Proficiency Evaluation in the Physician's Private Office
(By Lawrence J. McCormack, M.D., a Delegate from Cuyahoga County)

"The Committee in consideration of Emergency Resolution No. 24-70 made only two changes substituting in the first 'Whereas' quality for the word quantity and omitting the fourth 'Whereas.' The revised resolution is as follows:

WHEREAS, Much national discussion is ongoing concerning the quality of laboratory services of the American people with emphasis on the physician's private office.

WHEREAS, The present Congress is deeply occupied concerning mechanisms to evaluate the quality of clinical laboratory services,

WHEREAS, Continuing proficiency testing is recognized as an excellent method of self-evaluation by those providing laboratory services, BE IT THEREFORE

RESOLVED, That the House of Delegates of the Ohio State Medical Association recommend to its members that those clinicians supplying laboratory services participate in a self-evaluating proficiency program.

By official action, a motion to accept the recommendation of the committee, namely, that the Amended Resolution No. 24-70 be adopted, was carried.

AMENDED RESOLUTION NO. 2-70

Professional Liability
(By the Academy of Medicine of Cleveland)

"The Committee agrees with the intent of Resolution No. 2-70 as submitted by the Academy of Medicine of Cleveland. However, it has made several small changes for the sake of clarity and it submits the amended resolution as follows:"

WHEREAS, The incidence of malpractice claims has risen sharply, and

WHEREAS, Average claim costs have increased over several 100 percent in the last decade, and

WHEREAS, This results in tremendous increases in cost of professional liability insurance paid by physicians, and

WHEREAS, This rise in premiums contributes significantly to raise the costs of medical care, and

WHEREAS, Some states, notably Alaska, California, and Oregon have successfully revised the laws governing malpractice litigation in an attempt to make the process more equitable, less emotional, and more responsible to the public interests, THEREFORE BE IT

RESOLVED, That The Council of the Ohio State Medical Association be directed to recommend to the legislature the adoption of legislation changes in the public interest which will tend to spread the risks more equitably, discourage frivolous and speculative suits, give increased protection to physicians and medical teams acting in good faith, and limit awards to reasonable levels.

By official action, a motion to accept the recommendation of the committee, namely, that the Amended Resolution No. 2-70 be adopted, was carried.

SUBSTITUTE RESOLUTION NO. 4-70

Chiropractic
(By the Academy of Medicine of Cincinnati)

"After lengthy deliberation on this Resolution, the Committee felt that not only chiropractic, but all branches of medical practice are in need of constant reevaluation and reexamination. It appears the limiting factor on the reexamination by the State Board is financial. The Committee felt that the resolution as submitted should be altered and accordingly recommends the adoption of a substitute resolution."

By official action, the House of Delegates voted to substitute the original Resolution No. 4-70 for the committee's Substitute Resolution. In addition, the original resolution was amended by the removal of the words "introduce or" in the second "Resolved."

RESOLUTION 4-70

WHEREAS, It is the duty of the physician to protect, guard, and maintain the health of all he serves, and

WHEREAS, The practice of Chiropractic has been labeled as an unscientific cult by all who have objectively evaluated its principles, and

WHEREAS, The United States Department of Health, Education and Welfare has excluded Chiropractic from Medicare because of its lack of scientific basis, and

WHEREAS, The National Council of Senior Citizens oppose Chiropractic, and

WHEREAS, The United States Supreme Court holds that a state has the right to refuse licensing to Chiropractors unless they meet the standards of Doctors of Medicine, and THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association is opposed to the practice and licensing of Chiropractic, and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association cause to be introduced, a Bill in the next Session of the Legislature of the State of Ohio to ban the practice of Chiropractic in this State, and BE IT FURTHER

RESOLVED, To eliminate the future licensing of Chiropractors, unless the same standards required of Doctors of Medicine are met, and BE IT FURTHER

RESOLVED, That this resolution be implemented by all means available to the Ohio State Medical Association until such time as its intent is accomplished.

AMENDED RESOLUTION NO. 5-70

**Delegations from Ohio Chapters,
Student American Medical Association**
(By the Jefferson County Medical Society)

"The Committee was very impressed by the presentation of Resolution No. 5-70 by students from Ohio State University. We feel that this proposal will mutually benefit the medical students and the Ohio State Medical Association. It was felt that the resolution could be strengthened by the addition of a clause encouraging student involvement. Amended Resolution No. 5-70 is as follows:"

Preamble

The Student American Medical Association, a national professional association with local chapters at 87 of the nation's 95 medical schools, has a total membership of more than 24,000 medical students. There are chapters at the University of Cincinnati College of Medicine, the Ohio State University College of Medicine, the Case Western Reserve University School of Medicine. The new Medical College of Ohio at Toledo anticipates organization of a chapter in the not too distant future.

Membership in SAMA affords the medical student active participation in a professional organization devoted to the advancement of medical science and art, and the promotion of public health. More importantly, it affords him an active experience and preceptorship for the day when he joins the ranks of the local, state and national confederation of medical men devoted to those same high ideals.

Medicine must not only recognize but must afford opportunities of active participation by medical students in the activities of medicine's professional organizations; THEREFORE, BE IT

RESOLVED, That the Student American Medical Association chapters situated in the State of Ohio be invited to elect a delegate and alternate from each respective chapter to represent these future physicians in the House of Delegates of the Ohio State Medical Association, each delegate to enjoy the same rights, privileges and responsibilities as afforded a county medical society delegate without the right to vote, and BE IT FURTHER

RESOLVED, That all medical students in the State of Ohio be encouraged to attend all OSMA meetings, and become involved in its proceedings.

The House amended the amended resolution by inserting the words "without right to vote" between the words "self" and "and" in the last line of the first "Resolved." A third "Resolved" was deleted in its entirety. Mr. Philip Mika, a second-year student at The Ohio State University College of Medicine was granted the privilege of the floor to discuss the resolution. **By official action, Amended Resolution No. 5-70, as amended, was carried.**

RESOLUTION NO. 8-70

**Change in Requirements for
Emergency Room Service**
(By the Summit County Medical Society)

"In its discussion of this resolution, the Committee felt that the problems brought up were perhaps regional in scope. It does, however, under-

stand and agree with these problems. A review of the requirements of the Joint Commission on Accreditation of Hospitals of October 1969 casts some doubt as to whether emergency rooms are indeed an absolute requirement for accreditation. We recommend that information from all areas of the state be forwarded to the Emergency Medical Services Council for determination of emergency needs."

By official action, Resolution No. 8-70 was NOT adopted. This was in accord with the recommendation of the Resolutions Committee.

RESOLUTION NO. 9-70

New OSMA Councilor Districts
(By the Summit County Medical Society)

"This Resolutions Committee sympathizes with the desires of the members of Portage and Summit counties to have their own councilor district. However, from the testimony given on this resolution, it was obvious the sentiment of most of the members present was in opposition to piecemeal changes in districts or changes in the number of Councilors. Rather, it was felt if a revision is found to be necessary, a study be conducted of the districting of the entire state."

By official action, Resolution 9-70 was NOT adopted. This was in accord with the recommendation of the Resolutions Committee.

AMENDED RESOLUTION NO. 10-70

Spatter Protection
(By the Madison County Medical Society)

"This Committee recommends the adopting of Resolution No. 10-70 with several changes in wording. The amended resolution is as follows:"

WHEREAS, The Ohio Revised Code makes it mandatory for trucks to have mud flaps to protect other drivers, and

WHEREAS, Many new sport cars are delivered with one-half rear fenders which do not protect trailing motorists, BE IT THEREFORE

RESOLVED, That the Ohio State Medical Association refer this resolution to the Accident Prevention Unit of the Ohio Department of Health to be in turn referred to the U.S. Department of Transportation for appropriate action to the effect that new cars must have full rear fenders enclosing the tire sufficiently to prevent spatter.

"The final 'Resolved' of Resolution No. 10-70 was changed on the House floor to read as follows: 'Resolved, That the Ohio State Medical Association refer this resolution to the Accident Prevention Unit of the Ohio Department of Health to be in turn referred to the U.S. Department of Transportation for appropriate action to the effect that new cars must have full rear fenders enclosing the tire sufficiently to prevent spatter." **By official action, Amended Resolution No. 10-70, as amended, was carried.**

SUBSTITUTE RESOLUTION NO. 11-70

Improper Requirement for Physician's Signature
(By the Madison County Medical Society)

"The Committee felt that the problem was more general in scope and did not have available samples of the various state medical forms in question. It therefore recommended that the following substitute resolution be adopted:"

WHEREAS, Physicians are asked to complete many ambiguous and non-specific forms required by the State of Ohio certifying freedom from communicable disease, and certifying ability to perform certain functions, and

WHEREAS, There is a need to standardize such forms, THEREFORE BE IT

RESOLVED, That the OSMA formally request the Ohio Department of Health to adopt a standard form of certification for use by a physician in certifying his findings as to physical qualification of barbers, cosmetologists, and those requesting premarital examinations.

By official action, a motion to accept the recommendation of the committee, namely, that Substitute Resolution No. 11-70 be adopted, was carried.

AMENDED RESOLUTION NO. 12-70

Emergency Helicopter Schedule
(By the Madison County Medical Society)

"This Committee recommends approval of Resolution No. 12-70 with several small changes. The amended resolution is as follows:"

WHEREAS, The State of Ohio has instituted an experimental program of helicopter ambulance—evacuation—rescue, using Ohio National Guard Helicopters, members of the Ohio State University Hospital staff and the State Highway Patrol; BE IT THEREFORE

RESOLVED, Information relative to the availability of the helicopters, the time of day, week and month helicopters are to be in action in programmed areas, and the timetable of scheduling with State Highway Patrol be made available to coroners, county medical societies, non-metropolitan hospitals and their medical staffs.

By official action, a motion to accept the recommendation of the committee, namely, that Amended Resolution No. 12-70 be adopted, was carried.

RESOLUTION NO. 20-70

Establishment of Incorporated Group Practices
(By H. William Porterfield, M.D., a Delegate from Franklin County)

"The Committee is sympathetic to the intent of Resolution No. 20-70. However, the solution offered is one of many possible solutions. It contends that group practice is the best answer to the physician shortage — an unproven premise. In

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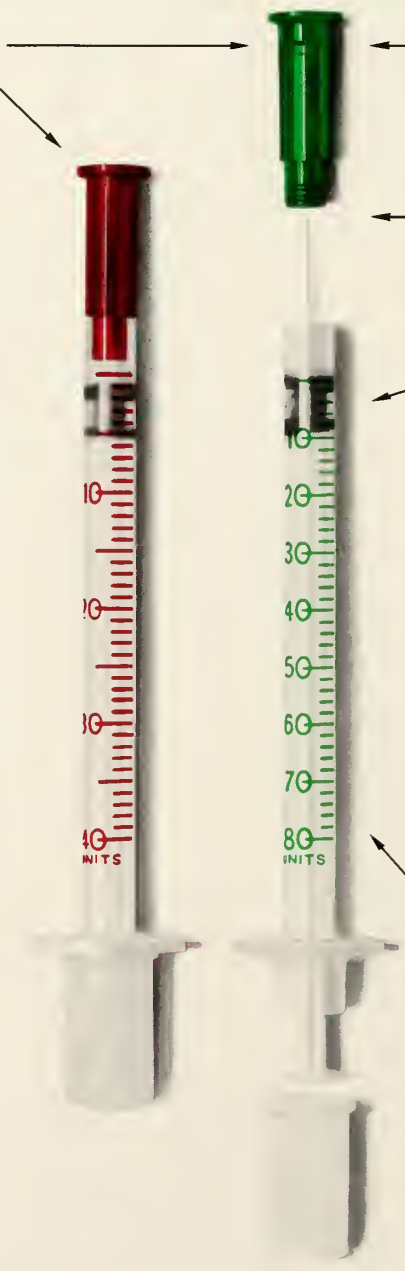
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addition to attempting to solve the problem of physician shortage by group practice it also makes recommendation regarding financing the method of delivery of professional medical services.

"Therefore, it was felt that further study identifying the areas of medical needs in the State of Ohio and the possible methods of meeting these needs is indicated, and the Committee urges that the House of Delegates instruct the Council to pursue this with all possible haste."

By official action, Resolution No. 20-70 was referred to the Council with instructions that Council report back at the next meeting of the House.

The members of the Resolutions Committee No. 3 are: Thomas E. Fox, Warren County; Jerry Hammon, Miami County; Paul E. Lyons, Marion County; Wesley J. Pignolet, Lake County; Mark Herbst, Stark County; Robert E. Rinderknecht, Tuscarawas County; J. R. Wells, Licking County; Thomas W. Morgan, Gallia County; Jasper M. Hedges, Pickaway County; Richard B. Belt, Richland County; Clarence B. Nyce, Wood County, Chairman."

By official action, the report of Resolutions Committee No. 3 as a whole, as amended, was approved by the House of Delegates.

Tribute to George Woodhouse, M.D.

Dr. Robert S. Martin requested privilege of the floor for the purpose of introducing the following resolution in tribute to Dr. George Woodhouse:

"The death of George Woodhouse has removed a distinguished Ohio physician. His service was long and faithful in behalf of the profession he loved.

"Recognizing his abilities his colleagues in this house elected him President of this State Medical Association 1958-59. He also was for many years Chairman of Ohio's Delegation to the American Medical Association.

"In that House he served with distinction and he was for ten years a member of that most important and influential group, the Judicial Council of which he was for two years its Chairman.

"In all his activities he brought credit and respect to this State and its physicians as well as the medical profession of his county.

"Be it resolved that this House of Delegates of the Ohio State Medical Association express its sorrow at his loss, and its sympathy to his wife Ann. We shall miss him and shall not forget him."

The resolution was adopted by a standing vote of tribute.

Inaugural Ceremony

Dr. Light administered the presidential oath of office to Dr. Richard L. Fulton. Dr. Light then presented the traditional silver tray and certificate of honor to Dr. Robert N. Smith, the retiring President. Dr. Smith presented the official gavel to Dr. Fulton and Dr. Smith received the past president's pin from Dr. Fulton.

Committees Named

Dr. Fulton presented the following committee appointments and they were officially approved by the House of Delegates:

Committee on Education — Dr. Glidden L. Brooks, Toledo, reappointed chairman for the ensuing year; Dr. Clyde W. Muter, Warren, reappointed for a term of five years, 1970-1975; Dr. Calvin P. Warner, Cincinnati, appointed for a term of two years, 1970-1972, to fill the unexpired term of Dr. Goffredo S. Accetta, Cincinnati.

Judicial and Professional Relations Committee — Dr. Homer A. Anderson, Columbus, reappointed for a term of five years, 1970-1975, and reappointed chairman for the ensuing year.

Committee on Public Relations and Economics — Dr. Luther W. High, Millersburg, reappointed for a term of five years, 1970-75, and reappointed chairman for the ensuing year.

Committee on Scientific Work — Dr. Robert E. Zipf, Dayton, reappointed chairman for the ensuing year; Dr. Vincent T. LaMaida, Cleveland, appointed for a term of five years, 1970-1975; Dr. Jack Schreiber, Canfield, reappointed for a term of five years, 1970-1975; Dr. Jack Tetirick, Columbus, appointed for a three year term, 1970-1973, to fill the unexpired term of Dr. Samuel Marable (deceased); Dr. Ralph G. Wieland, Cleveland, appointed for a three year term, 1970-1973, to fill the unexpired term of Dr. Isador Miller, Urbana, resigned.

Committee on Membership and Planning — Dr. William R. Schultz, Wooster, appointed for a two year term, 1970-1972, and appointed chairman for the ensuing year; Dr. Richard L. Meiling, Columbus, appointed for a term of five years, 1970-1975; Dr. William M. Wells, Newark, appointed for a term of four years, 1970-1974; Dr. Dwight L. Becker, Lima, appointed for a term of three years, 1970-1973; Dr. John H. Budd, Cleveland, appointed for a term of one year, 1970-1971.

The House of Delegates then adjourned sine die.

ATTEST: Hart F. Page
Executive Director

ATTENDANCE OF DELEGATES
OSMA House of Delegates
1970 ANNUAL MEETING

County	Delegate	First Session	Final Session
	FIRST DISTRICT		
ADAMS	Juan Young		x
BROWN	John R. Donohoo	x	
BUTLER	Robert P. Johnson	x	x
	James M. Smith	x	
	James F. Stewart		x
CLERMONT	Carl A. Minning	x	x
CLINTON	Edmond K. Yantes	x	x
HAMILTON	Ambrose H. Clement	x	x
	Frank P. Cleveland	x	
	Joseph G. Crotty	x	x
	William R. Culbertson	x	x
	Robert S. Heidt	x	x
	Harry K. Hines	x	x
	Stephen P. Hogg	x	x
	Elmer R. Maurer	x	x
	Clyde S. Roof	x	
	Albert E. Thielen	x	x
	Robert M. Woolford	x	x
	Frederick Brockmeier	x	x
	Eugene J. Burns	x	
	Eli Rubenstein		x
	Calvin F. Warner		x
	George D. J. Griffin		x
HIGHLAND	Clifford Foor	x	
	Walter Felson		x
WARREN	Thomas E. Fox	x	x
	SECOND DISTRICT		
CHAMPAIGN	Isador Miller	x	x
CLARK	John F. Harley	x	
	Ernest H. Winterhoff	x	x
	Wesley E. Knaup		x
DARKE	Gilbert Sayle	x	x
GREENE	Roger C. Henderson	x	x
MIAMI	Jerry L. Hammon	x	x
MONTGOMERY	William G. Cassel	x	x
	William J. Lewis	x	x
	William M. Porter	x	x
	Don E. Sando	x	x
	Franklin L. Shively, Jr.	x	x
	A. J. Gabriele	x	
	Robert E. Zipf		x
PREBLE	Chester J. Brian		x
SHELBY	Edward A. Link		x
	THIRD DISTRICT		
ALLEN	Fred P. Berlin	x	x
	Thomas L. Edwards	x	x
AUGLAIZE	Robert S. Oyer	x	x
CRAWFORD	Darrel D. Bibler		
HANCOCK	John C. Smithson	x	x
HARDIN	Clarence L. Johnson	x	x
LOGAN	Charles Browning	x	x
MARION	Paul E. Lyons	x	x
MERCER	James J. Otis	x	x
SENECA	Walter A. Daniel	x	x
VAN WERT	Alford Diller	x	
WYANDOT	Donald P. Smith		
	FOURTH DISTRICT		
DEFIANCE	Paul E. Brose		
FULTON	Francis E. Elliott	x	x
HENRY	Wilson J. Stough		
LUCAS	C. Douglas Ford	x	x
	R. A. Gandy	x	x
	Roland L. Kennedy	x	x
	Frederick P. Osgood	x	x
	Howard E. Smith	x	x
	H. C. Mack	x	x
OTTAWA	Cyrus R. Wood	x	x
PAULDING	Doyt E. Farling		x
PUTNAM	James B. Overmier	x	
SANDUSKY	Frank W. Ames	x	x
WILLIAMS	John E. Moats		x
WOOD	Clarence B. Nyce	x	x
	FIFTH DISTRICT		
ASHTABULA	Shepard A. Burroughs	x	x
CUYAHOGA	Joseph L. Bilton		x
	William F. Boukalik	x	x
	John H. Budd	x	x
	Henry A. Crawford	x	x
	Nicholas G. DePiero	x	x
	David Fishman	x	x
	John J. Gaughan	x	x
	John J. Grady	x	x
	Clarence L. Huggins, Jr.	x	x
	Roscoe J. Kennedy	x	x
	Vincent T. LaMaida	x	x
	Lawrence J. McCormack	x	x
	Hermann Menges, Jr.	x	x
	Pierce H. Mullallay	x	x
	James R. O'Malley	x	x
	A. Benedict Schneider	x	x
	George W. Petznick	x	x
	Frederick T. Suppes	x	x
	William V. Trowbridge	x	
	Alfred M. Taylor	x	x
	L. Philip Longley	x	x
	C. A. Colombi		x
	E. Peter Coppedge		x

County	Delegate	First Session	Final Session
GEAUGA	Alton W. Behm	x	x
LAKE	Wesley J. Pignolet	x	x
	John Cahill		x
	SIXTH DISTRICT		
COLUMBIANA	William S. Banfield	x	x
MAHONING	Gabriel E. DeCicco	x	x
	Joseph V. Newsome	x	x
	C. Edward Pichette	x	x
	Jack Schreiber	x	x
PORTAGE	David S. Palmstrom	x	x
STARK	William D. Baker	x	x
	W. B. Epps	x	x
	Mark G. Herbst	x	x
	William A. White, Jr.	x	x
SUMMIT	R. H. Champion	x	x
	Lynn James DeFreest	x	x
	Douglas M. Evans	x	x
	E. W. Cauffield	x	
	E. Gates Morgan	x	x
	Lewis H. Walker	x	
	J. L. Kloss		x
	Marshall R. Werner		x
TRUMBULL	Robert J. Paul	x	x
	Joseph L. Logan	x	x
	SEVENTH DISTRICT		
BELMONT	Thomas L. Ring	x	
CARROLL	Glenn Dowell	x	x
COSHOCTON	Robert R. Johnson	x	x
HARRISON	Janis Trupovnieks	x	x
JEFFERSON	Paul N. Mastros	x	x
MONROE	Byron Gillespie		
TUSCARAWAS	Robert E. Rinderknecht	x	x
	EIGHTH DISTRICT		
ATHENS	David Caul		
FAIRFIELD	Chester P. Swett	x	x
GUERNSEY	Robert A. Ringer	x	x
LICKING	J. R. Wells	x	x
MORGAN	Henry Bachman	x	
MUSKINGUM	George T. Thompson	x	x
NOBLE	Frederick M. Cox		
PERRY	R. E. Herendeen, Jr.		
WASHINGTON	Kenneth E. Bennett	x	x
	NINTH DISTRICT		
GALLIA	Thomas W. Morgan	x	x
HOCKING	Lethia W. Starr	x	x
JACKSON	John Zimmerly	x	x
LAWRENCE	Harry Nenni	x	x
MEIGS	Roger P. Daniels	x	x

County	Delegate	First Session	Final Session
PIKE	Albert M. Shrader	x	
SCIOTO	Chester H. Allen	x	x
VINTON	Richard E. Bullock	x	x
	TENTH DISTRICT		
DELAWARE	Tennyson Williams	x	x
FAYETTE	Thomas J. Hancock		
FRANKLIN	Paul M. DeMerit	x	
	Joseph A. Bonta	x	
	Ollie M. Goodloe	x	x
	Ben E. Jacoby	x	x
	Jack W. Miles	x	x
	H. William Porterfield	x	x
	Mark L. Saylor	x	x
	Donald W. Traphagen	x	x
	James H. Williams	x	x
	William P. Smith, Jr.		x
	Charles W. Pavey		x
KNOX	Henry T. Lapp	x	x
MADISON	Sol Maggied	x	x
MORROW	Joseph P. Ingmire	x	x
PICKAWAY	Jasper M. Hedges	x	x
ROSS	Joseph S. McKell	x	x
UNION	Paul R. Zaugg	x	
	ELEVENTH DISTRICT		
ASHLAND	Myrle D. Shilling	x	x
ERIE	Emil J. Meckstroth	x	x
HOLMES	Adam J. Earney	x	x
HURON	William R. Graham	x	x
LORAIN	Charles G. Adams	x	x
	H. E. Kleinhenz	x	x
	James T. Stephens	x	x
MEDINA	Richard W. Avery	x	x
RICHLAND	Richard B. Belt	x	x
	Carl M. Quick	x	x
WAYNE	A. Burney Huff	x	x
	OFFICERS		
President	Robert N. Smith	x	x
President-Elect	Richard L. Fulton	x	x
Past President	T. L. Light	x	x
Treasurer	James L. Henry	x	x
	COUNCILORS		
First	Paul N. Ivins	x	x
Second	George J. Schroer	x	x
Third	Dwight L. Becker	x	x
Fourth	George N. Bates	x	x
Fifth	P. John Robechek	x	x
Sixth	Maurice F. Lieber	x	x
Seventh	Sanford Press	x	x
Eighth	William M. Wells	x	x
Ninth	Oscar W. Clarke	x	x
Tenth	James C. McLarnan	x	x
Eleventh	William R. Schultz	x	x
	Totals	156	157

Attendance at the Annual Meeting

A Comparison of This Year's Attendance With Tabulations for Other Annual Meetings

IT IS SIGNIFICANT that members of the Ohio State Medical Association from 87 of 88 counties attended the 1970 OSMA Annual Meeting in Columbus, May 11-14. In fact, a total of 1160 OSMA members attended. A comparison of this year's membership attendance with figures for previous years is shown in the following tabulation. The overall registration was 3405 with the following breakdown: OSMA members, 1160; Ohio guest physicians, including interns and residents, 162; out-of-state guest physicians, 27; medical students, 224; nurses, dentists, technicians and miscellaneous guests, 1101; Woman's Auxiliary members, 254; scientific and health education exhibitors, 155; technical exhibitors, 322.

Following is a tabulation of registration figures for OSMA Annual Meetings from 1919 to the current year, followed by a breakdown of OSMA membership and registration by counties.

OSMA Annual Meeting Registration—1919 to 1970 Inclusive

Year	Place	Members	Guest Physicians	Medical Students	Woman's Aux.: Misc. Guests	Sc. and Tech. Exhibitors	Total
1919	Columbus	1173			264	92	1539
1920	Toledo	860			105	80	1062
1921	Columbus	1275			104	96	1503
1922	Cincinnati	1066			184	70	1341
1923	Dayton	1117			202	76	1414
1924	Cleveland	1301			180	109	1603
1925	Columbus	1204			361	107	1689
1926	Toledo	903			120	83	1125
1927	Columbus	1320			286	82	1705
1928	Cincinnati	916			92	80	1115
1929	Cleveland	1231			249	124	1619
1930	Columbus	1241			435	86	1775
1931	Toledo	826			198	50	1087
1932	Dayton	978			201	45	1226
1933	Akron	858			160	25	1049
1934	Columbus	1069			410	51	1539
1935	Cincinnati	973			197	84	1271
1936	Cleveland	1099			563	137	1818
1937	Dayton	1103			366	64	1551
1938	Columbus	1330			619	104	2068
1939	Toledo	1056			271	84	1426
1940	Cincinnati	1126			323	114	1589
1941	Cleveland—Joint Meeting with AMA						
1942	Columbus	1221			527	119	1880
1943	Columbus	544			160		717
1944	Columbus	830			411	130	1421
1945	No Meeting						
1946	Columbus	1262	130	65	507	157	2121
1947	Cleveland	1502	158	15	411	328	2414
1948	Cincinnati	1362	293	27	491	214	2387
1949	Columbus	1533	162	221	462	230	2608
1950	Cleveland	1587	260	102	707	376	3032
1951	Cincinnati	1208	162	185	647	352	2554
1952	Cleveland	1366	204	49	687	395	2701
1953	Cincinnati	1155	180	224	578	298	2435
1954	Columbus	1222	197	173	701	252	2545
1955	Cincinnati	1360	211	185	738	317	2810
1956	Cleveland	1601	338	120	1029	489	3577
1957	Columbus	1164	149	320	689	368	2690
1958	Cincinnati	1327	164	45	674	325	2535
1959	Columbus	1359	293	445	721	364	3182
1960	Cleveland	1642	489	48	1026	447	3652
1961	Cincinnati	1256	231	24	751	301	2563
1962	Columbus	1304	265	343	736	371	3019
1963	Cleveland	1502	336	19	893	441	3191
1964	Columbus	1428	332	297	1002	376	3435
1965	Columbus	1330	275	335	968	394	3302
1966	Cleveland	1484	309	22	865	355	3035
1967	Columbus	1327	286	394	1178	405	3590
1968	Cincinnati	1300	230	35	1287	613	3465
1969	Columbus	1344	219	208	1780	518	4069
1970	Columbus	1160	189	224	1355	477	3405

Registration by Counties

1970 Annual Meeting, and Membership Data

County	Total Membership Dec. 31, 1969	Total Membership May 11, 1970	Ann. Meet. Registration
Adams	9	9	1
Allen	134	136	22
Ashland	26	25	5
Ashtabula	58	56	3
Athens	42	39	3
Auglaize	16	16	4
Belmont	57	53	6
Brown	16	15	3
Butler	200	189	23
Carroll	9	9	3
Champaign	14	14	2
Clark	131	128	22
Clermont	18	19	3
Clinton	19	19	5
Columbiana	70	68	7
Coshocton	21	19	5
Crawford	41	40	8
Cuyahoga	2287	2162	108
Darke	25	24	5
Defiance	25	26	6
Delaware	25	25	8
Erie	63	61	10
Fairfield	50	51	17
Fayette	15	14	5
Franklin	972	893	295
Fulton	16	16	2
Gallia	39	33	4
Geauga	29	31	5
Greene	56	55	6
Guernsey	25	24	5
Hamilton	1300	1237	81
Hancock	45	42	4
Hardin	28	27	6
Harrison	7	8	2
Henry	12	10	1
Highland	18	18	2
Hocking	9	9	2
Holmes	10	10	4
Huron	30	27	6
Jackson	14	13	4
Jefferson	73	69	10
Knox	37	37	10
Lake	112	115	6
Lawrence	23	21	9

Registration by Counties (Contd.)

County	Total Membership Dec. 31, 1969	Total Membership May 11, 1970	Ann. Meet. Registration
Licking	69	69	15
Logan	15	16	4
Lorain	212	206	18
Lucas	639	595	47
Madison	13	13	4
Mahoning	343	335	12
Marion	69	68	8
Medina	57	57	10
Meigs	6	5	2
Mercer	19	20	4
Miami	65	60	10
Monroe	3	2	..
Montgomery	599	569	56
Morgan	3	3	2
Morrow	7	7	4
Muskingum	75	72	25
Noble	2	2	1
Ottawa	20	20	3
Paulding	8	8	1
Perry	7	8	1
Pickaway	22	19	8
Pike	6	9	1
Portage	61	63	6
Preble	6	6	2
Putnam	11	10	2
Richland	123	116	21
Ross	39	39	11
Sandusky	47	38	7
Scioto	66	62	10
Seneca	40	39	5
Shelby	23	21	4
Stark	347	345	26
Summit	587	568	29
Trumbull	137	136	9
Tuscarawas	54	53	7
Union	16	16	4
Van Wert	19	17	6
Vinton	1	1	1
Warren	14	14	4
Washington	32	30	7
Wayne	66	65	7
Williams	18	17	1
Wood	39	36	5
Wyandot	10	10	2
TOTAL	10,241	9,777	1,160



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Annual Meeting in Review . . .

THE ANNUAL MEETING PROGRAM listed perhaps a hundred or more meetings, programs, luncheons, dinners, get-togethers, etc. Obviously, with such an all-inclusive session, only the highlights can be covered in these pages.

The reader will find among reports the official proceedings of the House of Delegates, a presentation of elected officers, tabulation of attendance, the Woman's Auxiliary resumé of activities, a summary of outstanding exhibits, the President's address, Inaugural address, etc.

Photographs in this issue spotlight personalities and events in an attempt to capture the spirit of the meeting as well as typical actions.

The following briefs are presented in an attempt to spotlight personalities as well as emphasize some of the events that helped make another successful annual session.

Distinguished Guests

Distinguished guests at the Annual Meeting included key officers of State Associations in neighboring states: Dr. Walter L. Cawood, president of the Kentucky Medical Association; Dr. William A. Limberger, president-elect, Pennsylvania Medical Society; Dr. Maynard P. Pride, president, West Virginia State Medical Association; Dr. Lowell H. Steen, president, Indiana State Medical Association; and Dr. James S. Klumpp, a past president of the West Virginia State Medical Association.

Dr. Egeberg is Guest

A highlight in the Annual Meeting program was the appearance of Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, in the Department of Health, Education and Welfare, who was the featured speaker at the Wednesday afternoon General Session.

Dr. Egeberg discussed the tremendous upsurge in the public's demand for medical and health care, a demand brought about primarily by advances in facilities and techniques. He pointed out that only 10 to 11 percent of Medicaid costs represent doctors' fees.

Much of the criticism of the medical profession, the speaker said, is ill founded. Physicians, working 60 to 80 hours a week, are "not doing enough" in the eyes of many of those who find fault with the present system. The speaker further said that doctors who work long hours in private practice would tend to seek a more average work week if they were under a sponsored program.

Dr. Egeberg was hosted while in Columbus by President Robert N. Smith, who was instrumental in arranging his part on the Annual Meeting program. Dr. Egeberg is a former Ohioan, having practiced for several years in Cleveland.

The Power of Positive Thinking

Dr. Norman Vincent Peale was the distinguished guest speaker for the Thursday afternoon General Session in the Auditorium of the Veterans Memorial Building. The distinguished pastor of long standing of the Marble Collegiate Church of New York is well known to millions of Americans as a spiritual leader, writer and speaker.

His inspiring talk centered around the theme of the development of human character through dealing realistically with problems. The Lord put man in a world of problems, he said, and the more problems you have, the more alive you are.

Dr. Peale pointed out that the clergyman and the physician have many things in common since both must deal with the whole man—body, mind, and spirit.

His host while in Columbus was Dr. Donald J. Vincent, of Columbus, chairman of the OSMA Committee on Medicine and Religion.

AMA Executive Speaks

The Association was honored to have as guest speaker at the House of Delegates meeting Dr. Ernest B. Howard, Executive Vice-President of the American Medical Association.

Dr. Howard discussed the acute supply-demand imbalance in medical and health services, and pointed out that "availability" is the key word in the public's needs and not necessarily government financing.

Dr. Howard expressed his conviction that meaningful dialogue between the medical profession and the public is creating a better climate. The national climate of concern regarding medical and health facilities still is real, but it is becoming more and more an informed concern.

In regard to the CBS distorted documentary on health care, Dr. Howard reported that the AMA was still working on ways to tell medicine's

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genitourinary infections
gonorrhea
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mixed bacterial infection
osteomyelitis
otitis
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side of the story. The AMA's and the National Medical Association's demands for equal time so far had met with no more than cordial discussions, he said.

In regard to the team approach to medicine, Dr. Howard expressed his belief that as long as the medical profession maintains its role of leadership that the end product will be good.

Rex Morgan, M.D. Creator Speaks

"A Fictional Doctor Reveals What His Non-Fictional Patients Think About the Medical Profession." That was the title announced for his talk and that is literally what was discussed by Dr. Nicholas P. Dallis, guest speaker for the Tuesday evening kick off General Session for the 1970 Annual Meeting.

Rex Morgan, M.D., created by Dr. Dallis 22 years ago, is one of the most popular comic strips today and runs in some 400 newspapers in the United States and Canada and 35 foreign countries.

Dr. Dallis revealed that of the hundreds of persons who write in weekly about the fictional character, most of the comments are favorable to the medical profession. Many writers equate Rex Morgan with their own personal physicians, he said.

Dr. Dallis formerly practiced psychiatry in Toledo. He is now a resident of Scottsdale, Arizona, and devotes his full time to writing the continuity for three comic page features, Rex Morgan, M.D., Judge Parker, and Apt. 3-G.

Committeemen Named

Some 300 Ohio physicians play key roles in the operation of the Ohio State Medical Association by serving on its numerous committees. Committees meet periodically, study in depth matters pertaining to their respective responsibilities, and make recommendations to The Council or to the House of Delegates.

For a complete list of committee members, including new appointees, turn to the roster of officers and committeemen in the back section of this issue of *The Journal.*

The Yellow Pages

"Let your fingers do the walking," states a popular message of the Bell Telephone Company. But at the Annual Meeting it was a case of letting the Yellow Pages do the walking—the pages of course were attractive young ladies in suitable costume who manned the emergency telephone booth and relayed messages to physicians. Not only did the Bell System lend atmosphere to the meeting, but it rendered an invaluable service.

News Media Coverage

When doctors get together to bone up on modern medical practices, and to learn more about delivering better health and medicine to the public, that's news.

Representatives of the press, radio, and TV were present. They attended scientific sessions, interviewed speakers and officers of the Association, and reported events of the meeting from many angles. News releases on events of the meeting were sent to news media personnel in advance and during the meeting.

The Far East Fling

Social highlight of the meeting was held on Wednesday evening in the unique Saturn Room of the Sheraton-Columbus Hotel. Events started with a cocktail hour and costuming of guests for the Oriental mood. A delicious buffet dinner followed with dancing, then a double take on the floor show, plus an emcee who was preeminent in his art. A bit of audience participation gave the whole affair just that homey touch that makes for a perfect evening.

Pharmaceutical Firm's Catalog of Services Available

Smith Kline & French Laboratories recently released its SK&F Services Catalog 70/71, which offers 48 pages of services available to physicians.

Included in the illustrated catalog are medical films, booklets, pamphlets, periodicals, and the "Code 4" cardiopulmonary resuscitation training program.

The catalog is revised and published yearly by SK&F as part of the company's program to provide the medical profession with a wide range of useful services. A copy may be obtained from a company representative or by writing: Services Department E-10, Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia, Pa. 19101.

Woman's Auxiliary Report . . .

Address Presented Before the OSMA House of Delegates at the 1970 Annual Meeting in Columbus

By Mrs. Samuel L. Meltzer
1969-1970 President, Woman's Auxiliary to the OSMA

AS I STAND HERE before you tonight, I experience yet again a deep awareness of the opportunity and privilege that belong to the doctor's wife as they belong to very few other wives. The doctor's wife has the rare opportunity of serving the profession her husband represents. I say this because of another deep awareness of the full scope of responsibilities that belong to the medical profession as they belong to no other group.



Mrs. Meltzer

I would hope that the great majority of you look upon the Woman's Auxiliary as many strong and helping hands—YOUR strong and helping hands—rather than a projection of a ludicrous picture of chattering magpies who make much noise and accomplish nothing. I like to think—I dare to think—that we have earned the right to be considered an important adjunct to the medical profession.

We could not exist or function, obviously, without your willingness to let us exist and function as an auxiliary. The lifeblood of our organization flows evenly and effectively because of your ministrations of cooperation and your calls upon us to help. We want to urge you to continue to call upon us. Many of you already know what we are capable of doing. For those of you who don't, you'd be amazed at our tremendous potential!

On the Local Scene

In my many trips around the state this year, it has been revealing and rewarding to note how many community service activities were carried out by local auxiliaries in conjunction with their county medical societies. The Measles Immunization and Drug Abuse projects are just two outstanding examples.

Ohio has rounded out three decades this 1969-1970 Auxiliary year. We have 54 organized counties and a membership of 5,254. Thirty years is a long time in which to take a look backward. It gives one a start to realize that in 1940—the year of our birth (and I wish I could say it was the year of **my** birth!)—there were no television, hippies or yippies. We were just beginning to hear excited talk about something called nylon. Penicillin and the antibiotics had not yet made the public scene. If a woman had appeared in public in the mini-skirts of today, she would probably have been arrested! And—oh, yes—the image of the doctor was a beautiful one.

Much has changed in those thirty years. But, believe me, there has been no change in the purpose and dedication of the Auxiliary.

This year our emphasis focused on "We Must Communicate So That We Educate." Good communication on all levels can be the "Open Sesame" to accomplishment.

Well—here's a run-down of what Ohio's auxiliaries accomplished this year: Twenty-three counties had remarkably active and productive Children and Youth programs with considerable emphasis on Drug Abuse. We purchased 54 sets of "Milestones to Maturity"—eight remarkable letters for high school seniors—for all county auxiliaries to study for possible dissemination in their communities.

Twenty groups stressed the new Self-Defense for Women project under our Safety program. More than 1500 copies of a brochure prepared by us were distributed. Special meetings were held. Over 1,000 vigilante whistles were sold and the profit turned over to AMA-ERF. Three counties sponsored well-attended programs for the public in which key police officers participated with pertinent talks and realistic demonstrations.

Another new approach was the 13-week Health Reporter TV-Radio series which 14 counties requested. In each instance, of course, the county medical society OK'd the scripts. These 10-minute scripts were prepared principally from material in *Today's Health* and that obtained from the AMA. Our Central Office mimeographed the special announcements and the scripts. The local groups provided their own Health Reporters.

Twenty-eight counties performed outstandingly in Health Careers that included everything from Future Doctor and Nurse Clubs and Health Career days to bringing speakers and films before high school students, as well as placing the latest data on paramedical careers before guidance counselors.

Funds for Worthy Causes

Proudly I announce that Ohio auxiliaries this year contributed $31,810.00 for Health Career scholarships and loans.

In addition to that healthy contribution, our AMA-ERF contributions have reached over $40,000.00.—again, something I am proud to announce. Forty-eight counties continue to recognize the vital importance of AMA-ERF and to label it a major project.

This year we again offered to Ohio's colleges and universities AMA films for special showings on campus. Since early Spring, when the letter of reminder was sent out, seven such schools have shown films on Narcotics, Drug Abuse, and "Three Faces in Limbo". We not only process the orders through Chicago, but take care of whatever charges are involved. Future bookings are being set up for such requests as could not be handled because of conflict in dates.

Approximately 4½ tons of drugs were sent to World Medical Relief. So was an x-ray machine concerning whose tonnage I couldn't even hazard a guess. There were some $2500 in contributions for Project Hope.

Forty-five counties were very active in community service that included, in addition to some things already mentioned, hearing and eye tests, work with retarded children, booths at county fairs, venereal disease programs, Family Life Education, mock disaster performance, senior citizen programs and the providing of *Today's Health* subscriptions to local schools, libraries, and hospitals.

In this kind of report, I don't like to single out any one county. Yet I feel I must mention the Mobile Meals program that Lucas County organized and has since guided and participated in. It has grown by leaps and bounds. One hundred men and women are now being serviced with three meals a day, five days a week, on 13 routes. Four area hospitals are cooperating. Of the 550 volunteers now involved in this program, 275 are auxiliary members. I'm happy to report that two smaller counties are ready to embark on a similar program.

Another outstanding and continuing community service that should also be singled out is Hamilton's "Apple Tree"—the day nursery for children of hospital personnel. Not only has there been national publicity on this project, but international—and for a welcome change, praiseworthy publicity!

Other Projects

Close to 50 percent of our auxiliaries are engaged in some kind of mental health activity. It runs the gamut of special meetings, distribution of literature, representation on local boards, financial contributions, support of local levies, operation of a boutique for mental patients (where personal items may be purchased at a nominal cost; judge for yourselves—shoes and underwear for five cents!), Cuyahoga's newest—joining in with others to purchase a mini-bus for transportation of patients.

The Allen County auxiliary, in participation with two other agencies, brought Dr. Karl Menninger to Lima for a community program that attracted 1,000 persons.

And finally there is legislation. This year most of such activity centered around local politics and issues. Mahoning helped elect one of its members to the School Board. This spring, we revived our clipping service for OSMA, relative to the May primaries. We stressed OMPAC memberships. An auxiliary member serves on the OMPAC Board.

This, then, gentlemen, is a bird's-eye view of our principal efforts this Auxiliary year. We continued to publish our Workbook, our Ohio Medical Auxiliary News magazine and the special newsletter "To Keep In Touch".

I feel very strongly about the privilege of being an Auxiliary member. Unfortunately, there are still some doctors' wives who do not feel as I and over 5,000 others do. We need more members. We can never have enough members! Dare I ask those of you whose wives are not associated with the auxiliary, to go to bat for us—please? We even have a members-at-large category for those living in unorganized counties.

Surely this accounting tonight, sketchy as it is, should make you all realize—I hope—that a doctor's wife who is an Auxiliary member has a lot to show for it!

Thank you for giving us the unique opportunity to help the cause of medicine.



Investment Prognosis

By Frank Van Holte, Columbus

THE HISTORIC 69.28 point three day rise in the Dow Jones Averages at the end of May was sudden and unexpected and this reversal of the market tailspin has the experts confounded. The gloom of a market slump of about 25% in the past few months is difficult to pierce and there are those who consider this turnaround as merely a technical correction since the basic problems of inflation, increasing unemployment and declining corporate profits remain unchanged.

On the other side, we see many of the experts who feel that we have seen the end of the bear market and that this spectacular reversal should serve as a base for rebuilding market confidence. Perhaps our position will fall between these two outlooks. The shadow of war created by the sweep across the border of Cambodia still acts as a shroud over economic calculations. If the move proves to be successful, then much of the dubiosity and skepticism of the business outlook will be removed and we will indeed see a new bull market.

As investors, we must now carefully focus on the future which has been substantially improved as a result of the economy having endured a painful, but nevertheless effective purgation of values. The investment environment at this stage of the decline, is excellent and we now are seeing opportunities to buy at prices that are bargains to say the least. I suggest that you select quality securities with established earning power and avoid the highly speculative stocks. The price recovery of quality stocks is more certain than the recovery of stocks that were selling at high price earnings ratio. Many stocks will be slow to or perhaps never return to the high range which occurred in 1968. A spectacular drop in price does not portend a spectacular recovery. It is generally agreed that sales growth in the following industries will greatly exceed the national average in the next few years; aluminum, plastics, printing, communication, utilities, and above all, computers. The computer industry has been spectacular in its growth and in the next few years it will be even more resplendent. We will see a technological revolution in this industry alone.

I found it interesting to read recently, that the nation's labor unions are on the decline, and number in their ranks a steadily diminishing proportion of the labor force. Presently there are about 18 million union members, which is about the same number as of 10 years ago, despite the fact that there are millions of additional workers in employment and industries associated with unions. In fact, today only 25% of non-farm employees are members of a union compared to a high of 36% in 1945. Speaking of employees, did you know that General Motors has over 700,000 employees throughout the world and these employees receive total cash wages that are more than twice the personal income of Ireland?

I have been asked many times to give a specific example of the so-called bargains in the market today. Here is one that should impress you. Standard Oil Company (New Jersey) is the world's leading petroleum enterprise, accounting for about 15% of the estimated free-world crude oil production. It is currently selling at a price that provides a yield of almost 7% based on the $3.75 per share dividend. Incidentally, dividends have been paid since 1882—a pretty good record.

This huge company has over 100,000 employees and has three times as many employees overseas as the U.S. State Department. It has a six-million-ton tanker fleet which is half again bigger than Russia's. Its $17 billion in assets is almost equal to the combined assessed valuation of Chicago and Los Angeles. Earnings per share in 1969 were $5.78 and a rise in earnings is expected in 1970. The stock is currently selling for about 10 X earnings. This company is one of the bluest of chips and I am sure you will agree that it must be classified as a bargain in today's market. It has always been a trade mark as a safe investment.

This monthly feature is written exclusively for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Continuing Education Opportunities for Physicians in Ohio

August

Ohio Academy of General Practice, Annual Assembly, August 4-6, Sheraton-Columbus Motor Hotel, downtown Columbus; contact the OAGP.

September

Eleventh Annual Pediatric Postgraduate Conference sponsored by OSU College of Medicine, Department of Pediatrics, and the Columbus Children's Hospital, September 24-25; Contact Center for Continuing Medical Education, OSU College of Medicine, 320 W. Tenth Ave., Columbus 43210.

Ohio Chapter, American College of Surgeons, Neil House Motor Hotel, Columbus, September 25-26; Charles G. Livingood, M.D., Secretary, 211 S. Main Street, Dayton 45402.

October

Brain Tumor Symposium, Ohio State University College of Medicine, October 5-6; recent advances in tissue culture, biochemistry and chemotherapy will be stressed. Contact W. George Bingham, Jr., M.D., program chairman, Division of Neurological Surgery, 410 West Tenth Avenue, Columbus 43210.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Symposium on the Pancreas, Ohio State University College of Medicine in cooperation with the Central Ohio Diabetes Association; OSU Centennial event; October 6-7. Contact Center for Continuing Medical Education, 320 West Tenth Avenue, Columbus 43210.

American Institute of Ultrasound in Medicine, 15th annual meeting, Sheraton-Cleveland Hotel, Cleveland, October 12-15; program chairman, Adnan Sokollu, Sc. D., Office of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

Cleveland Course in Pulmonary Disease, Second Annual, St. Luke's Hospital, Cleveland, October 14-15; sponsored by Case Western Reserve University, the Tuberculosis and Respiratory Disease Association of Cleveland, the Ohio TB and Health Association, and the American Thoracic Society. Write Department of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

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On the Academy-Community Level

FOR AN EXCELLENT EXAMPLE of an effective public relations program developed and sponsored by a metropolitan County Medical Society, we turn to the Academy of Medicine of Cleveland and the annual report of its Public Relations Committee. Here is the entire report covering the 1969-1970 period.

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The activities of the Public Relations Committee have been interesting this past year. Efforts have been made to itemize activities. However, it has been difficult to maintain complete records of all of the activities of this busy Academy that qualify as public relations. Every member of this organization must carry on in his daily contact with the community in an affective public relations program as indeed this represents the real image of the physician to the people.

1. The Academy handled about 30,000 phone inquiries from the profession and the public for general information.

2. Mr. Lang moderated five ½-hour television programs on arthritis. These programs were aired on WKYC TV. The series was a cowinner of first prize in the annual Russell L. Cecil Award. This award is granted by the National Arthritis Foundation to recognize exceptional achievements by the broadcast media in dealing with the subject of arthritis.

3. The Academy assisted in producing a one-hour special on drug abuse. The program was aired on prime time in Boston, Detroit, Toledo, Milwaukee, Atlanta and Cleveland. Dr. William V. Trowbridge, as chairman of the Drug Abuse Committee also delivered 35 speeches to a total audience of 13,571 and presented a drug abuse seminar to over 600 teachers and law enforcement officers in the county.

4. Nine Med-Ed TV programs were produced this year by the Academy and aired on WVIZ, Channel 25. A professional evaluation firm surveyed the Academy membership to determine how much interest there was in the series. The results indicate that at least 38.5 percent of the Academy physicians watched one or more of the programs presented. This season-audience is well above the usually accepted figure of 20 percent that general interest, top rated TV shows attain.

5. Statistics on how many television news programs Academy representatives appeared are difficult to tabulate. Although a conservative estimate would be 40. The majority of these appearances resulted from interest in the Academy's programs on: Transportation of the Injured, the three-day Drug Abuse Seminar, the Rubella Sunday Vaccine Program.

6. TV appearances by physicians where they were on the program for ten minutes or more totaled 27 programs.

7. 260 "Health Lines" programs were produced by Mr. Lang in 1969. There were 102 separate broadcasts per week for an annual total of 5,460 programs. These broadcasts were carried on 18 commercial radio stations and replayed on Radio Station WBOE, and the Catholic Diocese Educational Network as a regular feature of the health education program in the schools. The "health lines" program covers a 22-county area and reaches an audience of 1,200,000 persons.

8. Radio appearances also increased in 1969. Most radio programs involved at least a ½-hour interview. Approximately 23 such programs were done with Academy representatives.

9. Community service announcements were also played on radio stations on an irregular basis. These involved health tips 30 and 60 seconds in length as well as announcements of Academy programs. Not all radio stations keep a record of how often these announcements are broadcast. But, judging from those who did report, and extrapolating from that, we can assume that at least 60 such announcements were aired last year.

10. Newspaper coverage of Academy activities last year was **excellent.** Over 100 news stories were printed on the Rubella Sunday Vaccine Program alone. These were carried in 35 newspapers in Cuyahoga County. In addition to these news stories, Academy activities generated 60 other newspaper stories. The majority of these were in the *Cleveland Press* and the *Cleveland Plain Dealer.* Not included in this figure are the many articles which probably appeared in the many weekly papers in Cuyahoga County. These stories were probably similar to the daily newspaper stories but with a local slant.

In the coming year, the activities of the Public Relations Committee should continue to spread in all spheres. It is hoped that our rela-

tionship with the newspapers might improve in more coverage dealing with the "good" in medicine will replace the frequent attacks on medicine.

The *Cleveland Physician,* the *Academy Memo* and Med-Ed TV have functioned well to serve our membership.

Possibly more effort can be made to increase our relationships with the other paramedical professions by joint meetings or projects.

The recent Rubella Program in our county has improved without question the physician's image.

Special recognition must be given to Mr. Alexander Lagusch who has labored hard, consistently and expertly in behalf of PR. Thanks too to Mrs. Hurwitz who has worked extra hours to provide speakers particularly for the drug abuse meetings.

Members of the Public Relations Committee:
Frederick T. Suppes, M.D., Chairman
R. Thomas Holzbach, M.D.
George P. Leicht, M.D.
Irving M. Liebow, M.D.
Joseph P. Martin, M.D.
Michael A. Petti, M.D.

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Speakers Bureau Report Cleveland Academy

Following is a summary of activities of the Speakers Bureau of the Academy of Medicine of Cleveland, submitted also by Dr. Suppes on behalf of the Public Relations Committee.

	Speeches	Audience
Speeches given May 1969-April 30, 1970	89	19,698
Speeches given by Mr. Robert A. Lang	16	892
Speeches given by Dr. Leo Walzer	10	1,000
Totals	115	21,590

American Physicians in Vienna to Convene

The American Medical Society of Vienna, founded in 1879, has proclaimed October 4-9, 1970 as "Medical Week in Vienna." The group will hold "Open House" in all of the local leading hospitals. Special arrangements will be made to receive physicians from abroad.

Physicians interested should direct correspondence as follows: M. Arthur Kline, M.D., Executive Secretary, American Medical Society of Vienna, 11 Universitatsstrasse, Vienna 1, Austria.

Columbiana County

A special meeting for doctors and their wives, of Columbiana County was held Thursday evening May 7, 1970 at the Travelers Hotel, East Liverpool, with sixty in attendance, to honor three fifty year members of the association.

Dr. Dudley Beaumont, Wellsville, Ohio and Dr. Arthur L. Turner formerly of East Liverpool, now living in Florida are both retired. Dr. Chester DeWalt of Columbiana is still in active practice. Fifty year pins, and engraved certificates provided by the Ohio State Medical Association, were awarded to each physician.

Dr. Samuel Rich, East Liverpool, Ohio, retired, celebrated his sixtieth year anniversary at the same occasion.

John A. Fraser, M.D. President of the County Medical Society served as chairman, offered the invocation, and presented the awards.

Short talks were given by the honored guests and others of the association.

—John A. Fraser, M.D., President

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Ohio Colleagues Honor OSMA President



Recognition night for Dr. Robert N. Smith, left, 1969-1970 OSMA President, was celebrated at the headquarters building of the Academy of Medicine of Toledo and Lucas County. With him above is Dr. Richard L. Fulton, Columbus, Incoming OSMA President, who was among distinguished guests in Dr. Smith's home town. At right, Dr. Frederick P. Osgood, gives a summary of Dr. Smith's attainments. The backdrop depicts Dr. Smith surrounded by an emblematic presentation of his professional accomplishments.

Hometown Celebration Centers at Academy Facilities

Dr. Robert N. Smith, retiring President of the Ohio State Medical Association, was honored by his colleagues and other friends on May 8 at the headquarters facilities of the Academy of Medicine of Toledo and Lucas County. Colleagues of Northwestern Ohio, other friends, and officials of organized medicine, gathered for the occasion.

Dr. Frederick P. Osgood, a past president of the Toledo Academy, and delegate to the American Medical Association, presented Dr. Smith with a gift of engraved Labino glass as a token of appreciation from the medical profession in the Northwestern Ohio area.

Of special significance was a backdrop displaying an enlarged photograph of Dr. Smith surrounded by emblems of the schools and organizations that played a part in his professional life.

What To Write For

Arthritis—The Basic Facts. This 20-page pamphlet, printed in large numbers by the Arthritis Foundation, summarizes for the public and the patient what is known and what can be done today about this disease. Copies are available free from local chapters or from the Arthritis Foundation's headquarters, 1212 Avenue of the Americas, New York, N. Y. 10036

Your Menopause, by Ruth Carson. This is Public Affairs Pamphlet No. 447, and one of a series prepared for the general public by this nonprofit educational organization. Copy may be requested for 25 cents from Public Affairs Committee, 381 Park Ave. South, New York, N. Y. 10016. Pamphlet will contain list of other publications available.

Obituaries

Edwin Homer Ellison, M.D., Milwaukee, Wisc.; Ohio State University College of Medicine, 1943; aged 51; died April 29; former member of the Ohio State Medical Association; Fellow of the American College of Surgeons, and affiliated with numerous other professional organizations; diplomate of the American Board of Surgery; recently professor and chairman of the Division of Surgery at Marquette University; formerly associated with the Department of Surgery at Ohio State University where he and Dr. Robert M. Zollinger reported on an ulcerogenic tumor of the pancreas, now designated the Zollinger-Ellison syndrome; survived by his widow, a son, and his mother.

Hubert Haymond Fockler, M.D., Columbus; Jefferson Medical College, Philadelphia, 1927; aged 72; died May 8; member of the Ohio State Medical Association, the American Medical Association, and the American Psychiatric Association; resident of Columbus in reent year; resigned as superintendent of the Athens State Hospital in 1962 after serving on the staff there for some 20 years; served with the Army Medical Corps from 1927 to 1941; survived by his widow, Dr. Beatrice Postle Fockler, who also formerly served on the staff of the Athens State Hospital; also survived by three brothers.

Richard Michael Gomer, M.D., Mt. Vernon; Faculty of Medicine, University of Vienna, 1908; aged 85; died November 6; member of the Ohio State Medical Association and the American Medical Association; resident of Mt. Vernon since the 1940's and practitioner there, specializing in dermatology.

Rodney Jones McKenzie, M.D., Cincinnati; Rush Medical College, 1938; aged 58; died March 12; member of the Ohio State Medical Association, the American Medical Association, the American Academy of Ophthalmology and Otolaryngology, and the American Society of Ophthalmologic and Otolaryngologic Allergy; diplomate of the American Board of Otolaryngology; practitioner for many years in Cincinnati, specializing in otolaryngology; served in the Medical Corps of the U. S. Coast Guard during World War II.

Louis Julius Markus, M.D., Cleveland; University of Louisville School of Medicine, 1926; aged 69; died May 21; former member of the Ohio State Medical Association; former private practitioner in Cleveland; later associated with the Veterans Administration and in recent years with the Ohio Industrial Commission; veteran of World War II; member of the Masonic Lodge; survived by a daughter and two sisters.

John Russell Rohrbaugh, M.D., Massillon; Western Reserve University School of Medicine, 1933; aged 61; died May 5; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Anesthesiologists; diplomate of the American Board of Surgery; practitioner of long standing in Massillon; active in numerous community affairs; former member and president of the school board; veteran of World War II and member of the American Legion; member of the Episcopal Church, several Masonic bodies, the Rotary Club, and other organizations; survived by his widow, his children, and a sister.

Edwin Joseph Stedem, M.D., Columbus; Western Reserve University School of Medicine, 1921; aged 74; died May 29; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons and of the International College of Surgeons; practicing surgeon of long standing in Columbus; chief of staff at Mt. Carmel Hospital; member of the faculty at the OSU College of Medicine; president of the Columbus Cancer Clinic for many years; past president of the Columbus Surgical Society; member of the Catholic Church; survived by his widow, a daughter, and a son.

Dorothy Mae Van Ausdal, M.D., Toledo; Ohio State University College of Medicine, 1953; aged 43; died May 26; member of the Ohio State Medical Association and the American Medical Association; resident of the Toledo and Maumee area for about ten years; served as Lucas County health commissioner; survived by a son, her mother, a sister, and three brothers.

Senn Fenger Whisler, M.D., Findlay; Chicago College of Medicine and Surgery, 1915; aged 79; died April 27; member of the Ohio State Medical Association and the American Medical Association; practitioner of long standing in the Findlay area; first health commissioner of Hancock County; physician for the Hancock County Home.

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

Report on the 1970 Annual Meeting

IN THE SPRING of 1940 thirty-nine wives of members of the Ohio State Medical Association met in the Hotel Gibson in Cincinnati to organize a state auxiliary to the OSMA. They paid fifty cents each in dues and elected one delegate to the national auxiliary convention.

In May of 1970 there were 254 registered at the annual meeting of the Woman's Auxiliary to the Ohio State Medical Association at the Christopher Inn in Columbus. The membership now totals 5,277, and 18 delegates will represent Ohio at the national convention. That is quite a contrast—no wonder the theme of the 1970 state meeting was "A Salute to 30 Years."

Preconvention Meetings

The Christopher Inn was already bustling with activity when I arrived for the state board luncheon Tuesday, May 12, at noon. Registration was underway and two committees had already had meetings — these were Central Office and Budget and Finance. Our board luncheon took on a festive air as we sang "Happy Birthday" to ourselves and blew out the 30 candles on the birthday cake.

First Business Session

The opening session of the House of Delegates, presided over by Mrs. S. L. Meltzer, president, convened at 9 a.m. Wednesday morning. There were 113 official delegates in attendance. The Invocation was given by Mrs. Paul Jones, first vice president, Muskingum County. Mrs. H. I. Humphrey, third vice president, Franklin County, led the group in the pledge of allegiance to the flag and the auxiliary pledge of loyalty.

Mayor's Welcome

Auxiliary members were warmly welcomed by Mayor M. E. Sensenbrenner of Columbus. You really need to hear this enthusiastic peppery speaker to appreciate his challenge. He called us to greater service: "There are mountains to climb, canyons to cross, and oceans to navigate." He showed concern about present unrest and stated, "Let's get radio and TV to tell what the good kids are doing!" Mayor Sensenbrenner urged auxilians to look to the future, to "build by faith, loyalty and service . . . to go—keep going—and help someone else to go."

Mrs. Richard Villarreal, president, Scioto County, gave the response to the mayor's welcome.

Introductions

Mrs. Karl F. Ritter, Allen County, chairman of guests, introduced the nine out-of-state auxilians who had joined us for our meeting. They included: Mrs. R. C. L. Robertson, president-elect, Woman's Auxiliary to the AMA; Mrs. Edward S. Maxim and Mrs. Francis P. Rhoades, president and president-elect of Michigan's auxiliary; Mrs. John A. Schneider, president from Pennsylvania; Mrs.

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Carl F. Goll
1001 Granard Parkway
Steubenville, 43952

President-Elect
Mrs. Russell L. Wiessinger
2280 W. Wayne Street
Lima, 45805

Past President
Mrs. Samuel L. Meltzer
2442 Dorman Drive
Portsmouth, 45662

First Vice-President
Mrs. Rudolf O. Cooks
15830 Van Aken Blvd., Apt. 401
Cleveland, 44120

Second Vice-President
Mrs. Daniel Wolff
3963 W. Bancroft Street
Toledo, 43606

Third Vice-President
Mrs. H. I. Humphrey
389 S. Drexel Avenue
Columbus, 43209

Recording Secretary
Mrs. Emil L. Barrows
7181 W. Aracoma Drive
Cincinnati, 45237

Corresponding Secretary
Mrs. F. A. Sunseri
301 Woodridge Drive
Steubenville, 43952

Treasurer
Mrs. Paul Hahn
122 Moore Avenue, N.W.
New Philadelphia, 44663

Stanley Chermish, president-elect from Indiana; and four members from West Virginia—Mrs. J. N. Jarrett, president; Mrs. Robert Tchou, president-elect; Mrs. Bruce Martin, 1st vice president; and Mrs. Willson Smith, national regional chairman of AMA-ERF.

Mrs. S. L. Meltzer presented Mrs. Reuben Gould, Cuyahoga County, convention chairman and Mrs. John Riepenhoff, Franklin County, co-chairman, and thanked them for a "magnificent job." Ruth said, "This is the first time we have not had a hostess county because of the change in location of convention made by OSMA. These women worked with committees scattered throughout the state . . . a bigger job than usual . . . problems of getting together . . . more correspondence and phone calls. The results speak for themselves—another great convention!"

Mrs. Gould thanked the many counties that had helped with arrangements. She stated that Lucile Egger, executive secretary, had carried much of the load; and that Mrs. H. I. Humphrey, Franklin County, as advisor, had been indispensable.

Greetings from OSMA President

Dr. Robert N. Smith, President, Ohio State Medical Association, welcomed auxilians and spoke warmly in appreciation of our work during the year. "There is much that you do that we are probably not even aware of except for results."

Ruth Meltzer, auxiliary president, then gave us her annual report. She stated that 47 out of 54 county presidents sent in details of their year's activities. A perusal of these reports gave her a remarkable tabulation of accomplishments. Mrs. Meltzer was particularly pleased with the many service projects in cooperation with county medical societies, as in the measles immunization and drug abuse programs. She spoke with pride of the fund raising achievements of the year: $31,810 for health career scholarships and loans; $2,500 for the ship HOPE; and over $40,000 for AMA-ERF. She stated that two new programs, Self Defense for Women, and the Health Reporter radio series, had proved very successful.

During her year as president, Ruth had stressed the need for communication and the importance of health education. She herself visited 21 different counties. She held individual orientation meetings with her new chairmen in June and July of last year. The theme for Fall Conference in September was "Confer—Create—Communicate". Our president kept us informed and inspired as she worked throughout the year to credit her theme, "We must communicate so that we educate."

Nominating Committee Report

Mrs. Malachi W. Sloan, II, Montgomery County, immediate past state president, gave the report of the Nominating Committee. Mrs. Meltzer asked for nominations from the floor for the various elective offices. Since there were no nominations, she declared the nominations closed. Mrs. C. A. Colombi, Cuyahoga County, moved that the nominees as presented by the Nominating Committee become the duly elected officers. Motion carried. They are:

President-elect—Mrs. Russell Wiessinger, Allen County

First Vice President—Mrs. Rudolf O. Cooks, Cuyahoga County

Second Vice President—Mrs. Daniel Wolff, Lucas County

Third Vice President—Mrs. H. I. Humphrey, Franklin County

Recording Secretary—Mrs. Emil L. Barrows, Hamilton County

Corresponding Secretary—Mrs. F. A. Sunseri, Jefferson County

Directors-at-large—
Mrs. H. W. Allison, Summit County
Mrs. Louis Loria, Trumbull County
Mrs. Howard E. Smith, Lucas County

District Directors—
2nd: Mrs. S. J. Glueck, Clark County
4th: Mrs. Willis L. Damschroder, Sandusky County
6th: Mrs. John R. Willoughby, Jr., Trumbull County
8th: Mrs. George F. Jones, Fairfield County
10th: Mrs. William A. Myers, Pickaway County

Mrs. Meltzer then asked for nominations from the floor for members of the 1970-71 Nominating Committee. As there were no further nominations, she declared the nominations closed. It was announced that election of the 1970-71 Nominating Committee would be by ballot at the designated voting hours.

National Officer Speaks

Mrs. R. C. L. Robertson, president-elect of the Woman's Auxiliary to the American Medical Association, was introduced. A capable and charming lady from Houston, Texas, Mrs. Robertson said she was most happy to be with us, particularly after circling the city of Columbus for 45 minutes during a storm the night before. She brought us greetings from the national board and an expression of thanks for all Ohio has done.

Mrs. Robertson spoke briefly of the national auxiliary "Yesterday, Today, and Tomorrow."

"Our objectives will always be the same—to help the AMA in its programs and to promote good fellowship among physicians' families." The national president-elect stressed the impact of electronic journalism in our world of today. She stated that people do not form their own opinions but want to be told what to believe. She emphasized that we as doctors' wives must be opinion makers, that we should highlight the dedication of medical men who are still treating the sick, helping the injured and promoting good health.

Priority projects for future as listed by Mrs. Robertson include: (1) to increase health manpower this next year, (2) to continue to raise funds for AMA-ERF, (3) to reach a membership goal of 100,000 by our 50th anniversary year of 1972, (4) to emphasize adult responsibility for good health of the family and community. Big challenges are easy to see because they are far off. It is the "everyday type of dragon to slay" that we are likely to miss. Each of us must ask herself, "What am I doing to make my community a better place in which to live?"

Looking Back

No birthday celebration would be complete without memoirs; Mrs. C. A. Colombi was asked to check back into the annals of auxiliary history and give us some tales of the past. Vi did such a beautiful job that I have asked her for a resume of her talk to include in a later column where there is space to do it justice.

AMA-ERF Awards

Mrs. Karl Ulicny, AMA-ERF chairman, announced that we are over our goal of $40,000 for AMA-ERF again this year. Describing herself as a "first class peddler," she said she was still selling stationery, aprons, copies of Ruth Meltzer's *Falls The Shadow*, memorial cards, etc. in the hall and in her room.

Mrs. Ulicny presented the following awards:

Allen County—the greatest increase per capita

Green County—the greatest increase over last year

Summit County—the largest amount from one county

Mrs. Malachi W. Sloan, Central Office Committee chairman, recognized the work of Mrs. James N. Wychgel, Cuyahoga County on the Central Office committee. Mrs. Wychgel, who was instrumental in setting up the Central Office for the auxiliary, is retiring from the committee this year.

Mrs. Malachi W. Sloan, Montgomery County, conducted a simple but impressive memorial service. An individual candle was lighted in memory of Mrs. Farrel T. Gallagher, one of our former state presidents; another candle for Mrs. Frank Gastineau, AMAPAC Board member from Indiana; and a third candle for Ohio's auxiliary members who had died this past year.

OMPAC Luncheon

Auxilians joined with OSMA members for the OMPAC luncheon Wednesday noon to hear political reporter, Robert D. Novak, of Washington, D.C. The speaker described President Nixon's present predicament in terms of three problems: (1) the political honeymoon is over; (2) the Cambodian crisis was not handled too well; (3) the economy is in a most serious condition. He stated that the only real cure is a quick wrap-up of Vietnam, that the Republicans are headed for trouble in November, and that the Democrat party is without leadership. He discussed the student unrest, the resultant politicizing of the universities. He refused to make any predictions for the 1970 elections except that "the prospects for major gains by the Republicans are not good in the House."

Somewhat depressed by the mood of political gloom established by the speaker, auxiliary members hurried from the luncheon and were dismayed to find the weather equally gloomy and unpredictable. Between showers, they hailed cabs or boarded chartered buses and headed for the Governor's Mansion.

Birthday Tea

The Governor's home provided a very gracious setting for the birthday tea in honor of Ohio's past state presidents, 14 of whom were present. Mrs. Carl Tetirick, Franklin County, served as chairman of arrangements for the tea. Mrs. James Rhodes joined state officers in the receiving line and welcomed auxilians to her home. The past presidents took turns in serving at the tea table which was loaded with delectable sandwiches as well as the birthday cake.

In a brief ceremony, Mrs. Meltzer, president, paid tribute to the past state presidents and thanked them for the work that they had done. Many have continued to serve the auxiliary in the years since their presidencies. Ruth presented each with a "birthday gift" in appreciation.

Mrs. Carl F. Goll, president-elect, presided at the county presidents' report session. In rapid-fire order the presidents presented capsule summaries of the year's activities. More details of the wonderful work of our counties will be given in this column at a later date.

"It Could Happen to You"

Thursday's breakfast workshop speaker, Policewoman Jeanne Bray of the Columbus Police

Department, spared no details in her discussion of personal safety. "Women take unnecessary chances . . . We're gullible and foolish . . . Safety is never out of date . . . Learn to expect the unexpected." She stated that female impersonators are common, showing several slides to prove how hard they are to spot.

Mrs. Bray discussed home safety in detail, gave precautions to observe when walking alone, and suggested safety rules for driving. She described everyday weapons available to women—hat pin, spray gadgets, nail file, rat-tail comb—but indicated that personal weapons such as kicking, scratching, fighting and screaming are most effective.

Mrs. Albert May, Marion County, chairman of the breakfast-workshop, had set the stage for this informative meeting with her table centerpiece, a hat decorated with all the everyday weapons available to women. She was assisted in planning by Mrs. Armin Melior, Scioto County.

Second Business Session

Mrs. S.L. Meltzer, president, called the second business session to order at 9:15 a.m. Roll Call chairman, Mrs. Saul Krasne, Cuyahoga County, reported that there were 106 official delegates present.

Dr. Richard L. Fulton, President-Elect, OSMA, addressed the House of Delegates and complimented auxilians on their record. He said that he was looking forward to a continuing fine and productive association with us.

Mrs. S.J. Glueck, Clark County, presented the Courtesy Resolutions in which deep appreciation was expressed to all who had helped to make this convention a success.

Mrs. Harry Nenni, Lawrence County, gave the report of the Election and Tellers Committee. The following were elected to the 1970-71 Nominating Committee: Mrs. S.L. Meltzer, chairman, and Mrs. Karl Ulicny from the Executive Board; Mrs. Jack Weiland, Mrs. Edward L. Doermann, Mrs. Arden Steele, Mrs. L.W. Like and Mrs. Murray Winchell from the general membership.

Mrs. R.C.L. Robertson, national president-elect, installed the new state officers of the auxiliary, investing them with authority, rank, power and responsibility. She presented each with a colored ribbon signifying certain attributes of the office she is to hold.

Inaugural Address

Our new president, Mrs. Carl F. Goll, said that her year of preparation for her responsibilities had been one of challenge, of fun and of friendship. She paid tribute to the untiring energy and leadership of Ruth Meltzer. She stated that we have had many goals, many themes, and many programs during the past 30 years and now must look to the future — "Let's get the job done, let's take action."

There are many continuing programs for all auxiliaries — legislation, health careers, community health, AMA-ERF, safety, to name a few. Mrs. Goll reminded us that every county is different and we should have some goals to fit our own county's needs. Then she outlined statewide goals for her year of action.

The first goal is to learn something about the "physician image." There is a lack of understanding between the individual physician and those he serves. Can we intelligently answer the questions about medical fees, house calls, etc.? Dru urged us to discuss the problems of medicine raised by the public. The role of the physician has changed but few understand it — people want to hang on to the old, and accept what they like about the new.

Mrs. Goll's second goal is that every auxiliary sponsor a health careers day. We all know that the health manpower shortage is critical. A health careers week will be set aside in March and all local groups are asked to cooperate. "If you have a WA-SAMA organization in your city, work with them."

Participation in legislative programs is Dru's third goal. "Become active in the political party of your choice; support levies or bonds for local issues."

As a final goal, Mrs. Goll asked that each county pick up the action theme. She urged all to continue their regular programs but stress the areas she had mentioned. "Let's motivate, participate and enjoy — let's make it a year to remember. The color is green, the sign is go, let's take action."

Immediately following the business session, Mrs. Goll and her fellow in-coming officers were honored at a reception given by the new president's county, Jefferson. Mrs. John W. Young and Mrs. William Mikita were chairmen.

Thursday Luncheon

Cuyahoga County's Gavel Club under the chairmanship of Mrs. Roscoe Kennedy was in charge of the "Out of this World" luncheon Thursday noon. Horoscopes were read, signs of the Zodiac appeared on the walls and tables, even the musical entertainers from Ohio State sang: "This is the dawning of the age of Aquarius."

The invocation was given by Mrs. D. Dudley Fetzer, Stark County. Mrs. S.L. Meltzer presented the honored guests: Mrs. R.C.L. Robertson and

the OSMA Advisory Board, Oscar W. Clarke, M.D.; Paul N. Ivins; M.D.; and Maurice R. Lieber, M.D. Dr. Clarke said that OSMA was particularly proud of the work of auxilians in the rubella campaign, drug abuse programs, and health career projects; and grateful for the funds given for health careers scholarships and loans, AMA-ERF and Project HOPE. He made one personal plea: "Start your man off on the day right."

Mrs. Woody Hayes, speaker of the day, urged us to find balance in our lives. While most of her talk was essentially humorous, she did inject some serious comments. Her own philosophy is that "you are as good as anybody in the world, and no better." She said, "Keep a sense of balance. Don't lose sight of what's really important. Too often we let ourselves go to pieces over relatively unimportant things."

Mrs. Hayes is a dynamic speaker. It was interesting to watch the faces of her audience — the rapt attention she commanded — the genuine laughter she invoked. She shared with us a few anecdotes of being the wife of a famous man. Auxilians decided there were similarities in the lives of wives of doctors and wives of coaches!

Accolades

And so another wonderful convention had come to a close. The new state board gathered for a brief meeting and picture-taking session as others packed up belongings and headed homeward. All the planning, all the cross-checking, all the last-minute changes had resulted in a smoothly functioning series of events in the past three days. The cooperation of the chairmen from various counties under the coordinating hands of Mrs. Gould and Mrs. Riepenhoff had produced an especially fine convention.

Special mention should be made of the "Early Bird Prizes" awarded at the beginning of each business session. These beautiful gifts were furnished by Cuyahoga County. We were all envious as the luck winners' numbers were drawn by Mrs. Kent Brown, county president.

The pleasant Pool Lounge Area of the Christopher Inn served as a gathering place each morning. Mrs. Louis Chaboudy, Scioto County was chairman of hospitality and was assisted by other members of her county. The auxiliary is indebted to Ohio Medical Indemnity, Inc. of Columbus and Medical Mutual of Cleveland, Inc. for the coffee and rolls served.

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Richard Peters, M.D.
Professional Committee
110 East Main Street
Youngsville, Pa.
814-563-7591



OHIO PHYSICIANS RECEIVE SMALL PERCENT OF MEDICAID DOLLARS

Ohio physicians received only 7 percent of the total dollars expended by the Ohio Department of Welfare in the Medicaid (Title XIX) program. Almost two-thirds of the total expenditures went to general hospitals and nursing homes.

OHIO MEDICAID (TITLE XIX)

Medicaid Assistance Program Expenditures
Jan. 1, 1969 — Dec. 31, 1969
(000 omitted)

Vendor Type	$ Expended 1969	% of Total
General Hospitals	$ 37,669	32.2%
Nursing Homes	$ 37,348	31.9%
Pharmacies	$ 15,160	13.0%
Physicians (M.D. & D.O.)	$ 8,215	7.0%
Mental Hospitals	$ 6,763	5.7%
Dentists	$ 4,163	3.6%
Medicare Part B Buy-In	$ 3,405	2.9%
Optometrists	$ 1,362	1.2%
Administration	$ 1,171	1.0%
All Other	$ 1,781	1.5%
Total	$117,041	100.0%

EDITOR'S NOTE: *The above is one of a series, the purpose of which is to inform the membership of pertinent facts about health care. The content will be intentionally brief and will present only a few significant facts in each issue. We trust that readers can thus more easily remember such information and use it as appropriate in discussions with patients and others. "Capsules" are prepared by OSMA Director of Economic Research, Charles F. Price. If you need explanation or elaboration on any of the data, please direct your requests to him at the OSMA office.*

Dr. Christopher A. Colombi, has been named to the Medical Advisory Committee of the National Association of Blue Shield Plans. Dr. Colombi is the Vice-President for Medical Affairs of Medical Mutual of Cleveland, Inc. (Blue Shield). The appointment was made by the National Board of NABSP, with headquarters in Chicago, Illinois.

Columbus Physician Will Join Dooley Team in Laos

"Working with underprivileged people gives me far greater satisfaction than any other type of work," explained one 27-year old physician, completing his internship in June this month at Grant Hospital, Columbus.

Acting on this principle, Dr. Larry Gene Griffith has joined the Thomas A. Dooley Foundation, the only private medical organization operating in Southeast Asia, to hang his medical shingle outside a jungle hospital on Khong Island, Laos.

Colleagues aren't surprised by his decision to serve this troubled corner of the world. Since childhood days in Texas, Gene Griffith has never taken the easy out. In junior high, hard work earned his title as "Most Outstanding Male Student." Following this, he attracted awards and honors like most kids collect dates. An honor student in high school, he graduated to West Texas State University where scholastic and personal achievement earned his inclusion in *Who's Who of American Universities.*

Success spurred him to pursue medical studies at the University of Texas Medical School. Before graduating in 1969, he took a six-month leave to practice "bush medicine" in Uganda, Africa. This experience awarded young Griffith direction. Upon his return he stated, "I am certain I want to make my career working among deprived and underprivileged people."

Dr. Griffith's assignment to Laos will more than compensate this drive.

Since 1957, when Dr. Tom Dooley initiated medical programs in Asia, Dooley doctors have been consistently awed by the prevalence of primitive disease. Leprosy, chlorea, tetanus and typhoid are a few of the diseases which challenge these contemporary medics. To compound problems, most Asians nurture up to five major illnesses at once!

In addition to serving the 50-bed Dooley Hospital on Khong Island, Dr. Griffith will travel the Mekong River on the floating medical clinic, Showboat. He will initiate trips to remote villages along the river to mend bones, deliver babies, issue shots and perform minor surgery. He will ferry serious cases to the base hospital for observation and treatment.

Assigned to Laos for an indefinite period, the young bachelor will amass a wealth of experience and not much else. Standard stipend for Dooley doctors is $300 per month. But Dr. Griffith isn't discouraged. "Many people sacrifice what they really want to do for the dollar. They wind up with a fat bank roll and an empty life. I plan to earn interest on experience, not money."

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An Equal Opportunity Employer

PSYCHIATRIC RESIDENCY — modern 120 bed hospital in Akron suburb, 40 mins. from Cleveland; comprehensive 3 yr. approved program. Area growing; high demand for psychiatrists. M. Menassa, MD., DME, Fallsview Mental Health Center, Cuyahoga Falls, Ohio 44222 (216) 929-8301.

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OFFICE AND EQUIPMENT for lease or sale; Columbus, W. Broad St. on Hilltop; write G. F. Millay, M.D., 2085 Northwest Blvd., Columbus, O. 43221; or call 614-486-7722.

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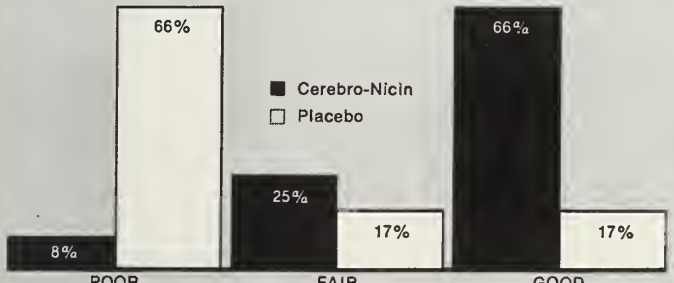
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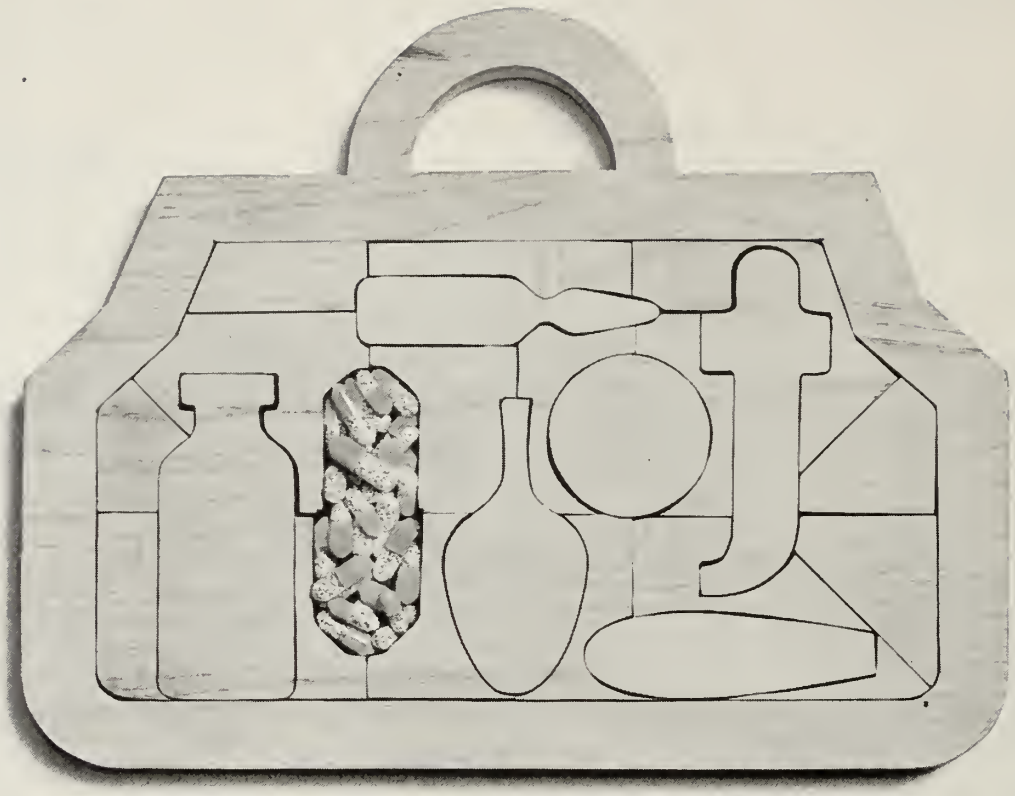
JOHN H. BUDD, M.D., Cleveland, Chairman of the OSMA Delegation to the American Medical Association, was elected to the AMA Board of Trustees at the Annual Convention in Chicago, June 21-25. See report beginning on page 826.

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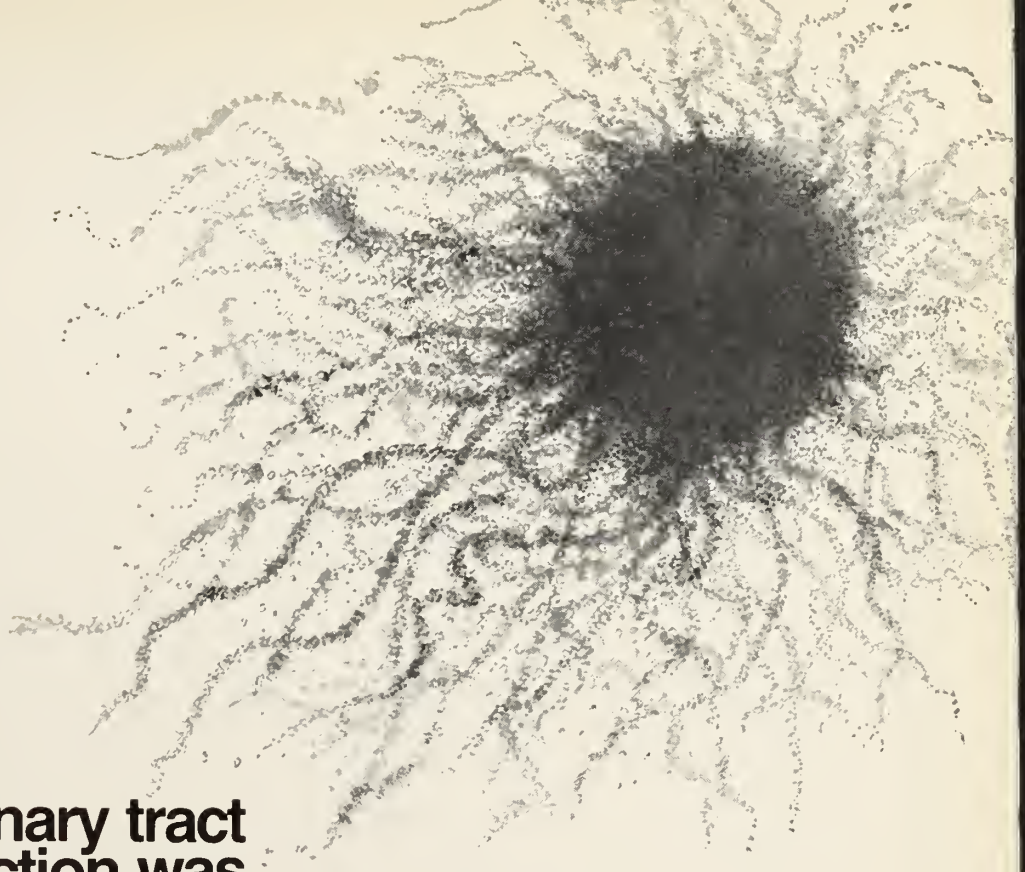
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Universal Health Insurance

By Robert J. Myers, F.S.A.
Chief Actuary, Social Security Administration

THE MOTTO of the actuarial profession is, in brief, "To substitute facts for impressions." In appearing before this Convention on such an important and complex subject as national health insurance and Medicare, I would certainly want to stay with the facts of the matter and not to bring in impressions and emotions, as do so many persons when they get into these areas.

To start off with, I would disavow any claim to being a complete expert on all aspects of this subject. Rather, my experience has only been in the financing aspects. And most certainly, financing, although important, is by no means of primary importance, but rather the actual provision of medical care is paramount, and in that area you, my audience, have far more expertise. In fact, I believe that this is the great weakness of many of the advocates of national health insurance—namely, that they do not have a real knowledge of many of the complex elements that go into providing high-quality medical care, much as they might claim that they do.

Before going any further, let me define what I believe the term "national health insurance" means, since nowadays many people are using it with quite different meanings. In my opinion, national health insurance means a program under which the entire population of the country, or virtually the entire population, would be provided all their medical care needs either directly by the Government through salaried physicians and other staff and through government-owned hospitals (socialized medicine), or else through private providers of service most of whose remuneration would come from government insurance programs (the Medicare or social insurance approach).

Extreme Proposals

Other types of proposals are currently being made that are called national health insurance plans, but, in my opinion, they should be categorized differently. Some proposals would completely change—or it might be said, scrap—present methods of providing medical care. It would seem to many people that these would be catastrophic in effect if put into operation in the near future, and I think that many of the advocates realize this but are merely using the proposals for talking purposes.

Other proposals would instead be harmonious with the present medical care system, which, despite strident charges from some quarters, has not been remaining static, but rather, in the desirable pattern of American democracy, has been gradually and steadily developing better and more efficient procedures as experience has indicated feasible.

The social insurance approach is taken in bills introduced by Senator Javits and Congresswoman Griffiths. Both bills are truly national health insurance, since they would apply to virtually the entire population and would provide virtually complete medical care, with the financing being through payroll taxes on workers and employers, plus a substantial matching government subsidy. The latter, of course, merely tends to hide some of the huge costs involved, since who else but workers and employers will provide the money for the general revenues financing?

Within a few years, after the full range of comprehensive benefits are provided, the cost of these plans will be at least 10 percent of payroll, regardless of how it is divided up, and could well be as high as 15 percent. Actually, no precise cost estimates are possible—as they can be made for a cash benefits program—because there are so many intangibles involved. For instance, there could be no certainty in the cost estimating process as to how the remuneration of physicians will be determined once there is a monopolistic, monolithic health insurance program. Nor is there any way to know how much services will be provided in such areas as hospitalization and drugs once

Editor's Note: On May 26, Robert J. Myers resigned as chief actuary of the Social Security Administration, announcing that he refused to be "muzzled and intimidated" by SSA Commissioner Robert Ball.

This article is the text of a speech presented by Mr. Myers before the Annual Convention of the Oklahoma State Medical Association, May 16, 1970.

The views expressed here are those of the author and not necessarily those of the Social Security Administration.


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the financial restrictions on patients have been largely removed.

At the one extreme, a national health insurance system can have a low cost by fiat of the Government if it merely allots a certain amount of money for health services and provides only what results therefrom—which has been very much the case under the British National Health Service. On the other hand, the financial sky would be the limit if a national health insurance plan provides all the services that people demand as readily and quickly available as possibly can be, without regard to whether this is medically necessary or desirable.

Putting Burden on Employer

A quite different approach has been taken by Governor Rockefeller. He advocates, in essence, that employers must have insurance or other programs covering certain basic health needs of their employees and their families, with a separate governmentally financed program of similar nature for nonemployed persons. In many ways, this would change the existing system very little, since the vast majority of employees in the country already have reasonably adequate private health insurance.

Another type of proposal is to grant tax credits for those who purchase, on a voluntary basis, comprehensive health insurance coverage from private insurers. The amount of the tax credit would be inversely related to family income, so that the very low income groups would receive their insurance policies without cost to them. Then, there would be a gradual tapering off for higher incomes, until, after a certain point, there would be no government subsidy involved. Such proposals would, of course, be financed from general revenues and would therefore mean higher taxes from one source or another for the general taxpayer. Proposals along these lines have been made by the American Medical Association and by Congressman Fulton and Senator Fannin.

A quite different approach has been suggested by Congressman Durward Hall. One part of his proposal would be to provide health insurance policies for the medically indigent and thus would replace the Medicaid program. The second part of his proposal would cover truly catastrophic illness for the entire population, defining "catastrophic" in relation to the family's income. Through the latter procedure, families would obtain the very necessary economic protection in those rare instances where medical costs run far in excess of the maximum limits in most health insurance policies.

The cost for this "catastrophic expense" plan would be met from general revenues, which seems

a most desirable approach because of the relatively few cases involved—so that establishing any insurance system involving premium payments would be administratively inefficient.

Why the Current Clamor?

One might well wonder why there is currently such a clamor for national health insurance or similar programs at this moment. Medical science has been making giant steps of progress, and the health and longevity of the American public is at an all-time high. Many different types of programs are being developed and put into effect to provide adequate health care for the very small minority of our population who are truly in poverty. And yet the advocates of socialized medicine are raising their voices ever louder to denigrate the existing medical situation. In turn, this causes more moderate groups to examine the situation and to come up with alternative programs of their own. Undoubtedly, this debate in our democratic society has certain advantages, but it does seem somewhat strange that it is now occurring.

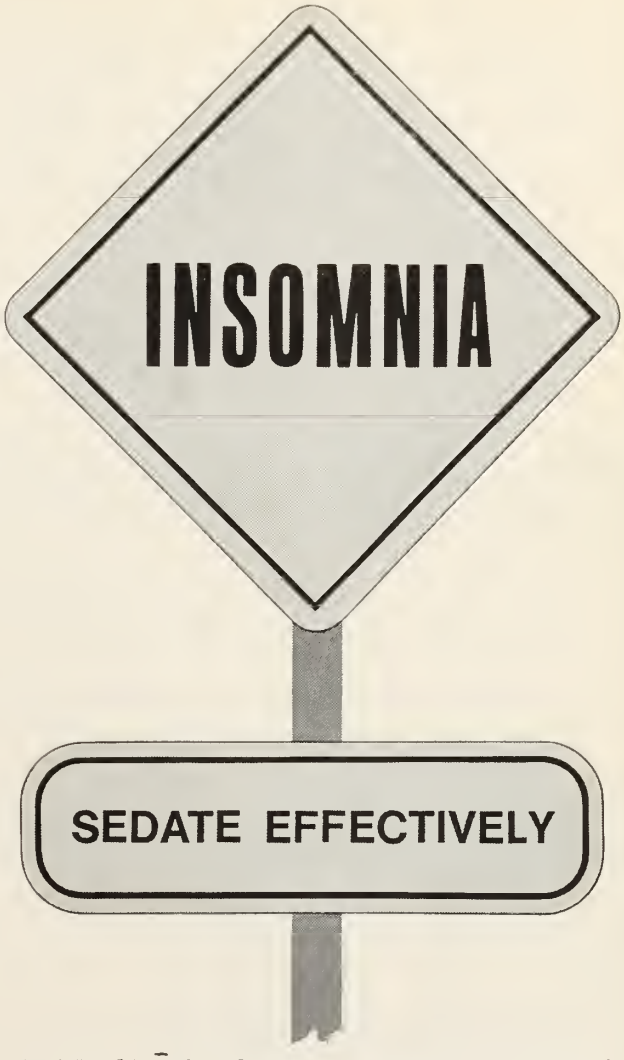
I think that there is a rather simple explanation of this occurrence—namely, the general inflation that we have been having the last few years. As you well know, the price level has been rising at an annual rate of about 5 percent, while at the same time the general level of earnings has been rising about 6 to 7 percent per year. At the same time, physician fees have also been rising at about 6 to 7 percent per year, while hospital costs have been increasing about 15 percent annually.

The much sharper rise in medical costs than in the general price level has been brought home strongly to the American public. For one thing, there is the natural tendency that people object most strongly to rising prices for things that do not give them immediate personal pleasure—and most medical costs hardly fall in that category, even though over the long run they are primary in achieving personal enjoyment and satisfaction of living.

Socializers Opportunism

The advocates of socialized medicine have seized this particular opportunity to achieve their goals or advance toward them, since they believe that the public can be aroused by the sizable increases in medical care costs. These advocates made a strong drive for national health insurance —preferably of the socialized medicine type—in the 1940's, but they failed to achieve their goal because of the general growth of private health insurance then (which they said could never achieve the success that it actually has).

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tent through the enactment of Medicare, these advocates of socialized medicine are again out in the open in full force, using as their appealing argument the recent large increases in medical care costs. As propagandists, they are quite willing to ignore and leave unmentioned several significant and crucial facts.

Soft-Pedaling the Facts

First, the largest increases in medical care costs have been for hospitalization—an area that is considered sacrosanct, because 95 percent of the short-stay hospital beds are in "non-profit" institutions.

Second, the **relative** trend of physician fees in the past five years has been almost exactly the same as it was in the preceding two decades—namely, increasing at about the same rate as the general earnings level.

Third, the illusion is fostered that, somehow or other, insurance is magic and has the inevitable effect of reducing costs. Actually, insurance does not reduce costs in the aggregate, but rather merely, although desirably, it spreads the costs among the insured group. Thus, none have extremely high costs, while others have little or no cost at all, but rather all persons have a uniform low or moderate cost (i.e. the premium rate).

In summary, on this point, it seems to me that the advocates of socialized medicine are trying to deceive the general public and sell them their old line of goods under a new guise—sharply rising medical costs which are unfairly blamed on physicians, when instead they are much more due to the rising general price and wage level and to the trend of hospital costs.

Dollar-and-Cents Facts

Now, let me turn to a subject on which I believe that I have considerably more expertise—namely, the financial status of the Medicare program, about which there has been much public misunderstanding. As you know, the Hospital Insurance (HI) program is financed predominantly by payroll taxes paid by and with respect to employed persons, whereas the Supplementary Medical Insurance (SMI) program is financed by premiums from the enrollees and matching government payments.

The cost-estimating problems have been much greater for the HI program than for SMI. Under HI, the attempt is made to provide adequate financing over a 25-year period by establishing a proper schedule of contribution rates. On the other hand, under SMI, the premium rate is determined for only a short advanced period, now annually.

The cost of the HI program over the next 25 years as now estimated is somewhat more than twice as high as the original estimate made in 1965, when the legislation was enacted. To say the least, this is a very professionally embarrassing situation. My actuarial colleagues in the private insurance sector in 1965 believed that my estimates were too low, but even their higher estimates are now only about half of what the cost apparently will be over the next 25 years.

Primary Reason

What are the reasons that this very significant discrepancy occurred? The primary reason is the rapid and completely unexpected escalation of hospitalization costs that occurred in the past and that is quite likely to continue for at least a few more years in the future. Before 1965, hospitalization costs had been increasing about 7 percent annually, and there seemed some indication that this rate would soon taper off. Instead, with the war in Vietnam and the accompanying economic effects, and to some extent, with the introduction of the Medicare and Medicaid programs, hospitalization costs since 1966 have jumped by 15 percent annually. To the best of my knowledge, nobody in 1965 made any prediction that this could possibly happen.

The other factor—and a much less significant one—is the extent of hospital utilization. I had initially estimated utilization of about 3.2 days per person per year. And my insurance colleagues had estimated somewhat higher. But both of us were well below the current experience of about 4.0 days per person per year. My current cost estimates not only use this figure as a starting point, but they also allow for a small increase in hospital utilization each year for about the next decade.

Now turning to the SMI program, my actuarial cost estimates have been much closer to the mark. Once again, this is a point of evidence that contradicts the claim that physicians are largely, or even entirely, responsible for the costs of the Medicare program being much higher than anticipated! Specifically, the SMI premium rate is, by law, supposed to be determined so as to finance adequately the benefits and administrative expenses on an accrual basis. By the latter term is meant that the costs incurred in a certain period, even though payment therefor is made subsequently in some cases, is to be matched up against the income from premiums and government contributions for that period.

As the actual experience developed, the initial premium rate of $3.00 was too low, but only by about 7 percent. Although technically speaking, it might be said that this made the program financially insolvent, nonetheless it could continue to operate on a cash basis because of the inherent

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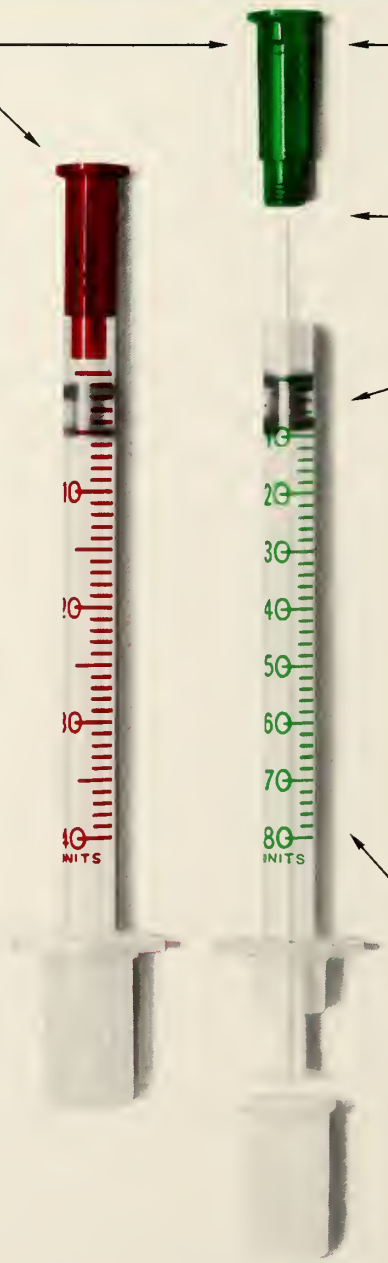
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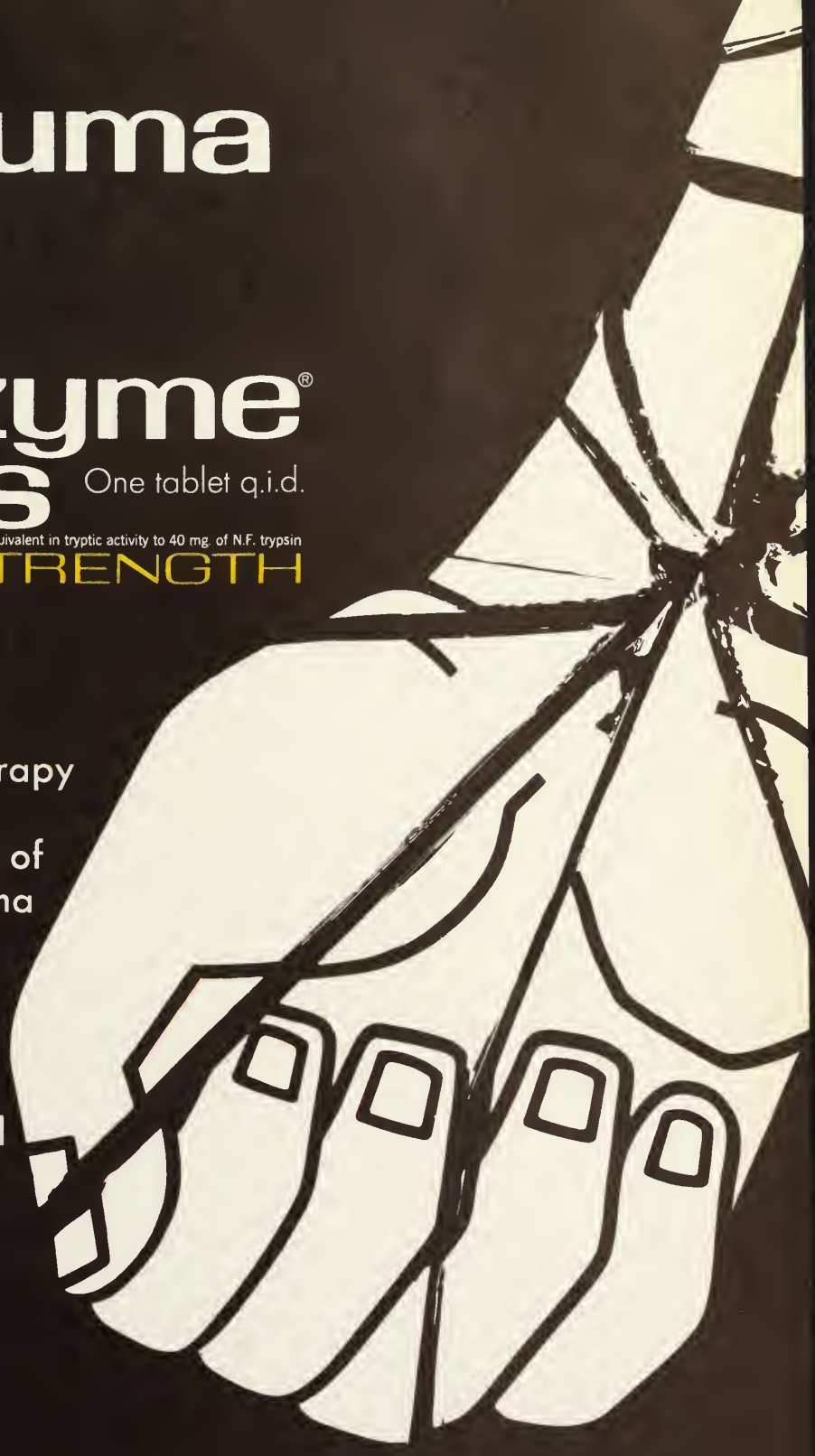
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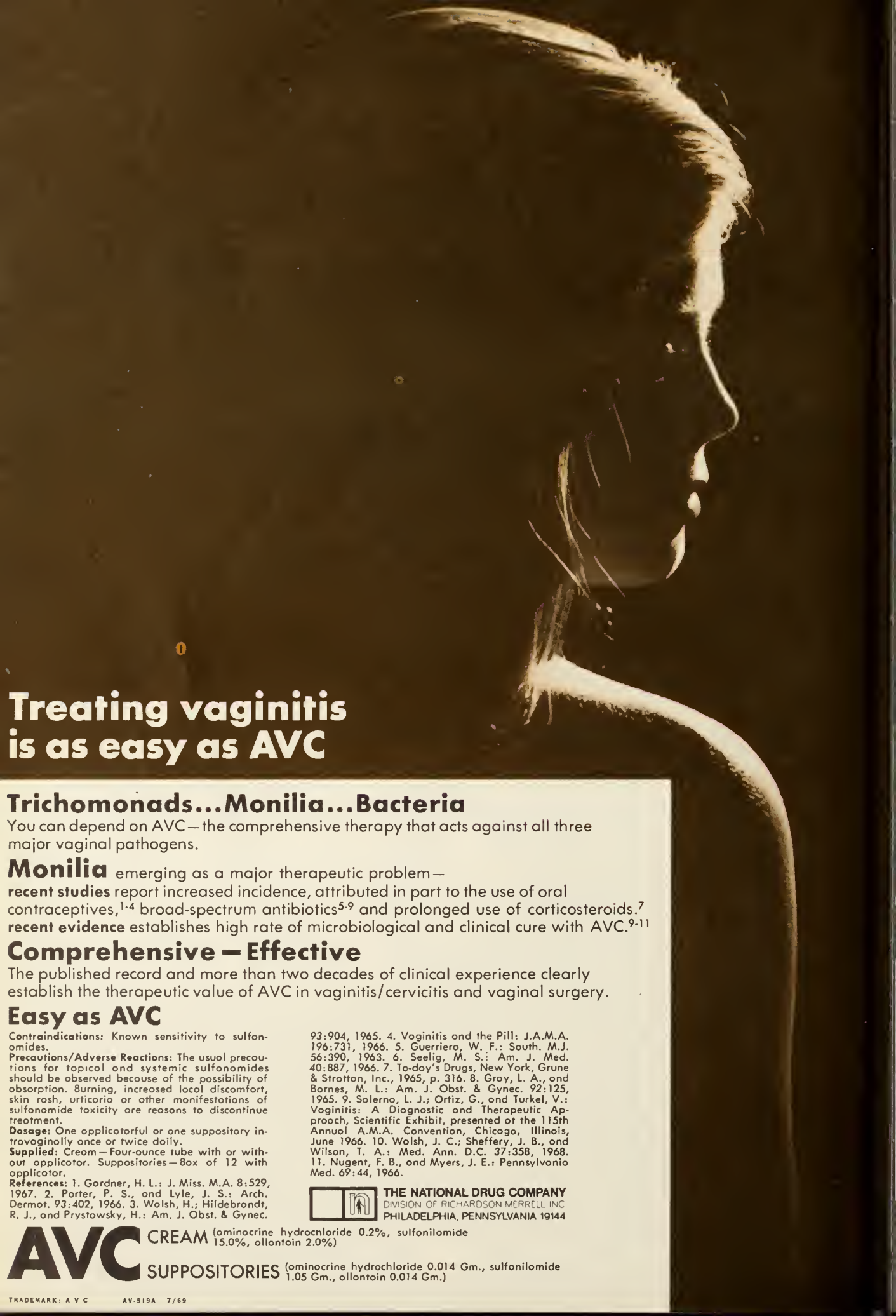
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References: 1. Gordner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., ond Lyle, J. S.: Arch. Dermot. 93:402, 1966. 3. Wolsh, H.; Hildebrondt, R. J., ond Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Voginitis ond the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-doy's Drugs, New York, Grune & Strotton, Inc., 1965, p. 316. 8. Groy, L. A., ond Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., ond Turkel, V.: Voginitis: A Diognostic ond Therapeutic Approoch, Scientific Exhibit, presented ot the 115th Annuol A.M.A. Convention, Chicogo, Illinois, June 1966. 10. Wolsh, J. C.; Sheffery, J. B., ond Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., ond Myers, J. E.: Pennsylvonio Med. 69:44, 1966.

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lag between the time when medical services are rendered and when the program makes payments therefor.

The premium rate was then changed to $4.00, in part because some new benefits were provided, in part to recognize that the initial rate had been too low, and in part to make allowance for likely future increases in physician fees and other costs covered by the program and in utilization of services by the enrollees. Once again, after the experience had developed and had been analyzed, it was found that the premium rate had been promulgated at too low a level—again by about 7 percent. Part of this small discrepancy was due to an influenza epidemic and part was due to somewhat higher increases in fees than had been estimated. Still, the system was able to function on a cash basis for the reasons indicated previously, and there was a trust fund balance of several hundred million dollars.

Arbitrary Determination

Then, it became necessary in December 1968 to promulgate yet another premium rate, this time for the year beginning July 1969. Secretary Wilbur J. Cohen, who was to go out of office in a few weeks as a result of the election of President Nixon, had the legal authority to promulgate the premium rate at any amount which he determined, but the Congressional intent was that such rate should be based on actuarial analysis and computations. Nonetheless, Secretary Cohen ignored the actuarial recommendation of a rate of at least $4.40 and instead continued it at $4.00.

He took this action on the grounds that he would, in essence, freeze physician fees (but not other costs under the program) at the existing level—even though he would not be around to see that this was done! Moreover, he had the temerity to say that he was taking this action to help President Nixon, since this would mean less cost to the General Treasury for the matching contributions! Of course, what he did not say was that his action would virtually bankrupt the SMI Trust Fund—as it has actually done—and would therefore cause his successor greater embarrassment by forcing him to promulgate a much higher premium rate the next time.

And all this has actually occurred. The balance in the SMI Trust Fund at the end of next month will probably be only about $50 million, or the equivalent of only about one week's outgo. Secretary Finch found it necessary last December to promulgate the new premium rate, beginning in July, at $5.30 per month, and he forthrightly followed the actuarial recommendation despite the widespread political criticism it evoked.

Freezing Physician Fees

Now let me turn briefly to the matter of the freezing of physician fees in the past. Let us also consider current proposals for the future, as the Nixon Administration has recommended and as the House Ways and Means Committee has adopted in a bill that it has recently reported out.

I do not claim to have the answer as to whether physician remuneration is too high or too low, but I am convinced that the recent trend in physician fees is entirely justifiable in relation to other prices and to salary levels in general. The justifications made by former Secretary Cohen for freezing physicians fees for Medicare purposes do not seem to me to be in accordance with the intent of the law.

When Medicare was enacted, the principle was that reimbursement would be made on a reasonable-charges basis, as determined by the physician's customary charges to all his patients and by the prevailing level of physician charges in the locality. With respect to the latter element, I believe that there was the misconception that, in a given area, the vast majority of the physicians had about the same general charge structure and that only a few "society" physicians had much higher fees.

Assuming this to be the case—and I believe that, in actual practice, it is really not so—then the intent of considering prevailing charges was to reduce only the few instances of much-higher-than-average charges. In fact, the underlying intent of the legislation in this respect was that the SMI program should consider physician charges in the same manner as was, and still is, done by the large group insurance companies, who take a very flexible view of the situation and only reduce charges for reimbursement purposes when there are obviously excessive charges or fraudulent ones.

Control of Physician Fees

Instead, the administrative operation of the SMI program was established on a quite different basis, with painstaking and costly procedures devised so as to examine closely all charges.

In my opinion, this advance planning was done solely for the eventual control of physician fees on a very stringent and different basis than was originally envisioned in the law. Some of this rigid control has already come to light, and some people would like to have much more of it in the future. And the apparatus has been constructed to do exactly this!

Underlying all of this is a belief on the part of many of my colleagues that physicians now (and in the past as well) have exorbitantly large

incomes and that their incomes should be reduced —or at least held down in the future as prices and other salaries rise. Some of these colleagues are civil service employees, but incredibly, a few are political appointees of the Johnson Administration who have not been replaced by the Nixon Administration, despite their strong philosophical views favoring the former.

Some very stringent procedures, as well as the supporting "logic," were developed to justify the freeze of physician fees that former Secretary Cohen imposed and that Secretary Finch has been virtually compelled to continue. Actually, I am not certain that this freeze had any real effect. Like many other economic controls, it may have pushed in the inflationary balloon at one point, only to have it push out in a counteracting manner in another place (such as more utilization or such as charging for some items previously furnished without charge).

One might reasonably think that the term "customary charge" means what the physician is currently charging his patients, just as though he had a sign listing his fees posted in his office. Instead, the peculiar interpretation has been evolved which says, in essence, that a fee is not customary until it has been in effect for about six months, and then "custom" cannot change for another year. No such illogical limits prevail in other economic areas—as, for example, utilities being granted an increase in their rates on a certain date because they are economically justified, but then not being allowed to put them into effect for 18 months because of a "customary" provision. In the same way, such artificiality has been introduced in the "prevailing charges" concept, so that there too an 18-month lag is present.

Seeking a Flat Fee

A proposal has currently been made by Secretary Finch that, in the future, the prevailing-charge limits on whatever are determined to be the customary charges of a particular physician shall be the present allowable prevailing charges increased by an index made up partially of changes in the general level of wages and partially of the changes in the general cost level of living. Since the latter usually rises at a lower rate than the former, which rises at about the same rate as physician fees, this would mean that, over the course of time, the prevailing-charges limit would gradually apply completely to each physician, rather than his customary charges. So, there would eventually be a flat fee schedule under SMI for all physicians in a particular locality, determined

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by the Government. This is quite different from the original approach in the Medicare legislation of paying reasonable charges of physicians!

The physicians of this country have been neatly trapped by the social planners, who secretly envy their high incomes, whether real or only apparent, and thus criticize them on any possible grounds. The intent of the Medicare program was that persons aged 65 and over should pay the same physician fees as younger persons, and thus should not be second-class citizens by being given lower, "charity" rates. Now that the physicians have charged in this manner, they are severely criticized! If they had artificially held down their fees for Medicare patients, then they would have been subject to the danger that the social planners would have pointed out that Medicare was operating very well and at a low cost and that therefore it should be extended to the entire population. You can't win!

The only possible solution to this apparent dilemma would be the development of a feeling of mutual trust and confidence between the Government and the medical profession. This certainly does not exist now—and for good cause. It was quite understandable why this situation did not prevail under the Johnson Administration. It seems almost inexplicable that there has been no change in the current Administration. Perhaps the reason for this is the fact that a number of high-ranking political appointees of the Johnson Administration in the Social Security Administration and in the Public Health Service who develop policy, even though perhaps not finalizing it, have not yet been replaced.

Political Liberals at Work

I cannot conclude without saying a few words about the cash-benefits program, Old Age, Survivors, and Disability Insurance. I deeply believe that this is a very necessary and desirable program and that it is now, and has always been, soundly financed. I believe, as you may know from some of my writings, that there are grave potential dangers ahead because the political liberals, or expansionists, when they get in office again will make strenuous efforts to change the program so that it will no longer be a floor of protection.

Instead, these proponents wish to see the Government provide virtually complete financial security to nonworking members of our society through government means. In the process, they would destroy almost completely all individual efforts through private savings, private insurance, and private pension plans. I believe that this would have catastrophic effects on people as individuals and, further, that it would have the side effect of greatly weakening or destroying our private enterprise system because of drying up much private investment capital.

The thing to beware of is the introduction of government subsidies into our social insurance systems that are now supported entirely by payroll taxes. Such subsidies give the appearance of being a painless way to expand greatly the benefits of the program, since nobody appears to have his pocketbook tapped therefor, whereas increases in payroll taxes are easily discernible and, accordingly, subject to taxpayer resistance.

The Daily Jeffersonian, of Cambridge, recently published a feature article on Dr. James A. Toland, regarding his activity in conducting classes in oil painting at the Cambridge Area YMCA. A former private practitioner in Cambridge, Dr. Toland is now on the professional staff at Cambridge State Hospital.



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Medical Sciences Building --- Cincinnati



This architect's sketch shows the Medical Sciences Building approved for construction as a major unit in the University of Cincinnati College of Medicine Facilities. Plans call for an increase in the medical student enrollment from 110 to 192 per class when the building is available.

Cincinnati Facility Will Increase Student Body

A grant of $34,690,000 for construction of a 10-story Medical Sciences Building at the University of Cincinnati College of Medicine has been approved by the Bureau of Health Manpower of the U.S. Department of Health, Education and Welfare.

It is the largest construction grant for medical education ever given by the Federal government, Dr. Clifford G. Grulee, Jr., dean of the College of Medicine, said.

The facility will be located on the Cincinnati General Hospital grounds adjacent to the new eight-story hospital which was opened in September, 1969. The two structures, both major units in the Medical Center, will be connected at several levels.

Designed by Ellerbe Architects of St. Paul, Minn., the building will make possible a significant increase in the present student enrollment of 110 per class. The college plans to admit 192 per class when the building is available. It is hoped to have construction completed in September, 1973.

Total construction cost of the building is estimated at $44 million. Total project cost is set at $53.5 million. In addition to the Federal grant, the project has $17 million from the state and $1.8 million from the University.

Plans for the new building are based on flexibility. Laboratories will be placed around a utility core. A library-information center and outlets from the Medical Center's closed circuit television network, already in operation, will be additional learning tools in the new Medical Sciences Building. Building plans show 820,000 square feet of floor space.

The exterior of cast stone and brick will blend in with the new Cincinnati General Hospital structure.

Dr. Robert M. Dumm, Kent, was one of four alumni to receive the Distinguished Service Award of Kent State University.

Northeast Ohio Wins 8 of 10 News Media "Heart" Awards

The Northeast Ohio Chapter of the American Heart Association won eight first-place awards, including the "Best Ohio Heart Story," and two second-place awards in the 1969-70 Public Information Contest sponsored by the Ohio State Heart Association.

The state contest recognizes the year's most outstanding stories concerning the Heart Association's varied programs and the "heart" problem itself. This past year, there were ten different categories, encompassing both daily and weekly newspapers, company publications, national publications, radio and television.

Local winning entries included:

The *Plain Dealer,* first place in the Educational Division of the Daily Newspaper Category, for the feature on Irvine H. Page, M.D., which appeared in the Sunday Magazine section on June 1, 1969. Written by Margaret Taylor, this story was also named "Best Ohio Heart Story" in the judging.

The *Plain Dealer,* first place in the Research Division of the Daily Newspaper Category, for the full-page research grant story by Fraser Kent, medical writer.

The *Plain Dealer,* first place in the Community Services Division of the Daily Newspaper Category, for the full-page story on the Work Classification Clinic by Fraser Kent.

The *Cleveland Press,* first place in the Human Interest Division of the Daily Newspaper Category, for the full-page feature on Cuyahoga County's 1970 Prince and Princess of Hearts which was written by Joe Collier, medical writer.

WKYC-TV, first place in the Television Category, for its "Open Lines" program, hosted by Ron Becker, which was aired on Heart Sunday. The program was produced and directed by Joseph Weber.

A-M News, first place in the Company Publications Category, for the three-part series on "Heart" written by Don Whittaker. (*A-M News* is the internal publication for Addressograph-Multigraph Corporation.)

Occupational Hazards, first place in the National Magazine Category, for the article on the Work Classification Clinic which was written by Carl Musacchio, associate editor.

Winning second-place honors were WUJC-FM, the radio station at John Carroll University, for its six-part series, entitled "Heart-to-Heart Forum," and the Cleveland edition of *The Call* and *Post* for its story on the 1970 Prince and Princess of Hearts.

Announcement of the winners was made at a special awards luncheon held during the recent annual meeting of the Ohio State Heart Association in Columbus. Plaques were presented to both representatives of the winning media and to representatives of the Northeast Ohio Chapter of the American Heart Association.

* * *

Of the ten first-place awards offered by the Ohio State Heart Association, two were won in other areas of the state.

In the weekly newspaper category, the award went to the *Girard News,* in Trumbull County, for an article written by Pamela Lovejoy.

In the radio field, the award went to station WLW, Cincinnati, and named Dick Murgatroyd, producer of the Bob Braun Show.

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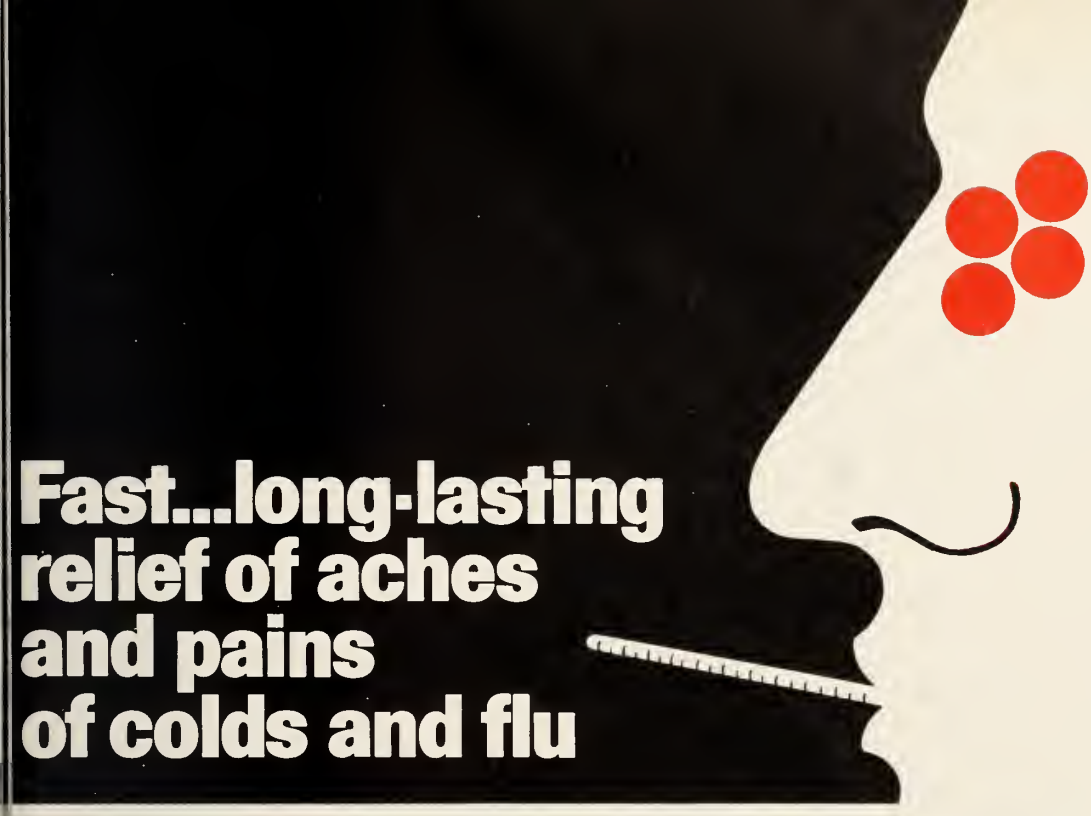
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Available: Bottles of 12, 36 and 60 tablets.

and we "Quote"

Famous American Writers and the Bottle

"Alcoholism is unevenly distributed among groups. More men than women are alcoholic, more Irishmen than Jews, more bartenders than bishops. The group, however, with possibly a higher rate of alcoholism than any other consists of famous American writers.

"Whether, as Hemingway said, most good writers are alcoholic is uncertain, but apparently a large number are. Of the seven Americans who were awarded the Nobel Prize for literature, four, according to their biographers, were alcoholics and a fifth drank heavily. If we compile a list of well-known American writers of the past century, quite possibly one third to one half could be considered alcoholic."—Donald W. Goodwin, M.D., *JAMA*, April 6

The Niche for a Physician's Assistant

"Therefore, the development of these Physician's Assistants in our state is indeed commendable. They know their limitations as they do their qualifications. In our practice (which consists of over 11,000 families in our active files for two physicians), the P.A.'s have proven good on taking and dictating histories, suturing minor lacerations and assisting with physical exams on males, children, and infants. Of course, they do not prescribe. They have been carefully screened, are clean-cut, and perform many additional jobs in laboratory work, the taking of blood samples, changing dressings, and follow-up visits to hospitalized patients. Also, they are efficient in pulmonary and inhalation therapy techniques. They maintain the line between diagnosing and treating on the one hand and helping to do those things on the other—the fine line between physician and physician's assistant. Our experience with the Duke P.A. program leaves us well pleased. . . .

"An innovative effort by the medical profession to increase health care manpower in North Carolina is through our Medical Society's leadership in the new Physician's Assistant program. Only by unselfish, capable, and courageous leadership will this country escape the far less competent who are striving for acceptance, leadership, and authority in the care of human ills." — Ernest W. Furguson, M.D., in the *North Carolina Medical Journal*

For an Epitaph, A Few Lines of Type

"For when he did not publish, did he not get up at night? And when he did not head a department, were there not lives that were saved, fears to be allayed, pains to assuage, and were there not griefs that must be softened? The barest of notices demands the most thoughtful of between-the-lines reading, and the least spectacular of obituaries, includes, without recording it, a lifetime of service.

"When a doctor dies, one or two seemingly dull lines are not really dull, and an inch of type is as high as the sky. He healed and he comforted, and his death notice is his shining badge of honor." — *The Nebraska State Medical Journal*

A Phenomenon of Many Dimensions

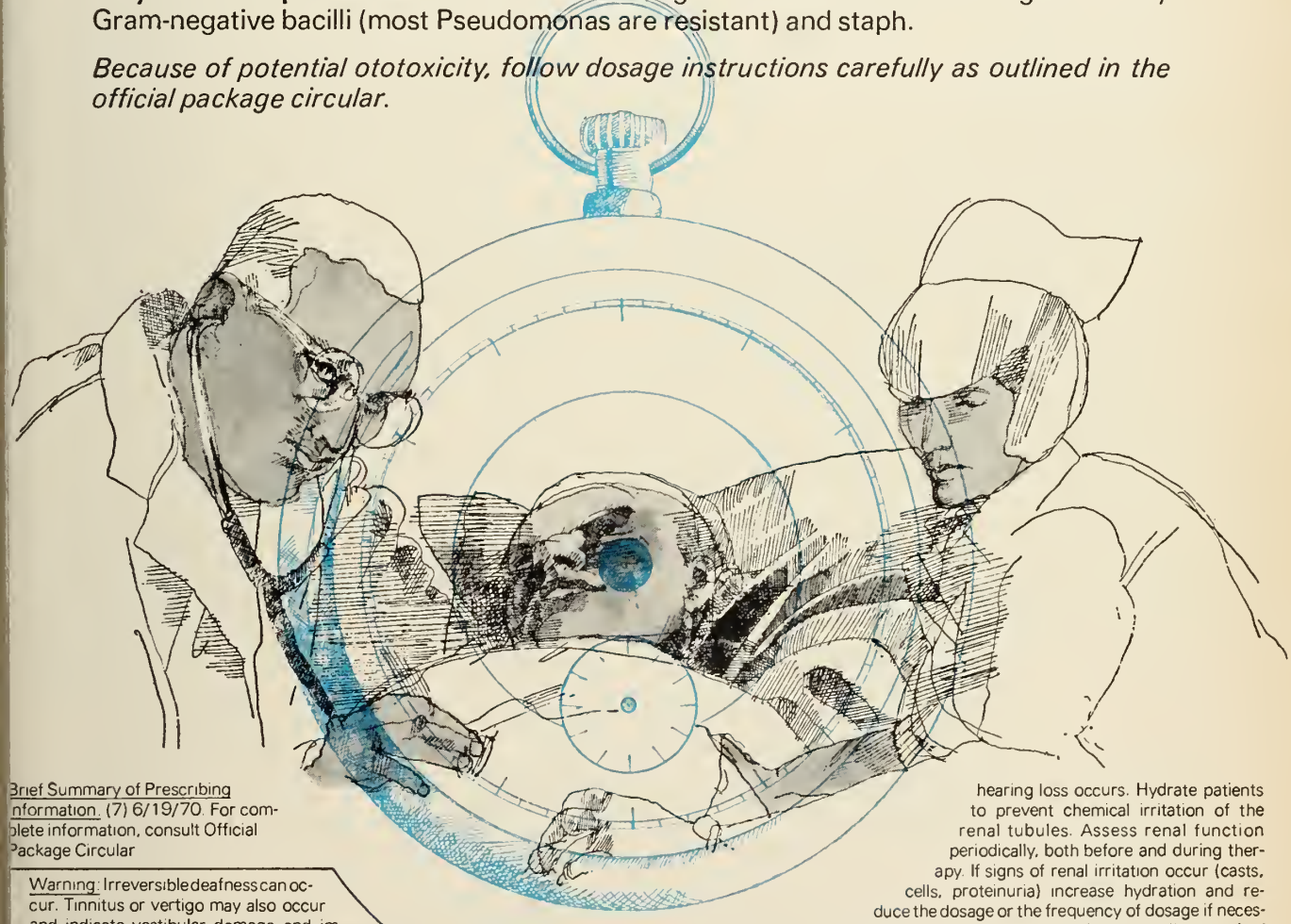
"The past few decades have witnessed a series of significant biological, psychological, social, and cultural changes affecting adolescents which, no doubt, have had an impact on the pattern and number of teen-age out-of-wedlock pregnancies. First, the onset of puberty has advanced considerably; boys and girls nowadays mature earlier. Second, boys and girls mix much earlier and are free socially with one another. Third, the family and the school have relaxed their control over the activities of adolescents. Fourth, in the past available free time, recreation, or leisure activities of adolescents were more structured; this provided orientation for them that is now missing. Fifth, the values governing intimacy among adolescents have been liberalized tacitly. In fact in many instances parents pressure adolescents into dating activities. Sixth, the age of economic independence has gradually increased, forcing many otherwise mature

A valuable hospital antibiotic —when there is no time

in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



Brief Summary of Prescribing Information. (7) 6/19/70. For complete information, consult Official Package Circular

Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established.

Indications: Serious infections due to susceptible strains of *E. coli*, Proteus sp., *A. aerogenes*, *K. pneumoniae*, *Serratia marcescens* and *Mima-Herellea*. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary—In azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.

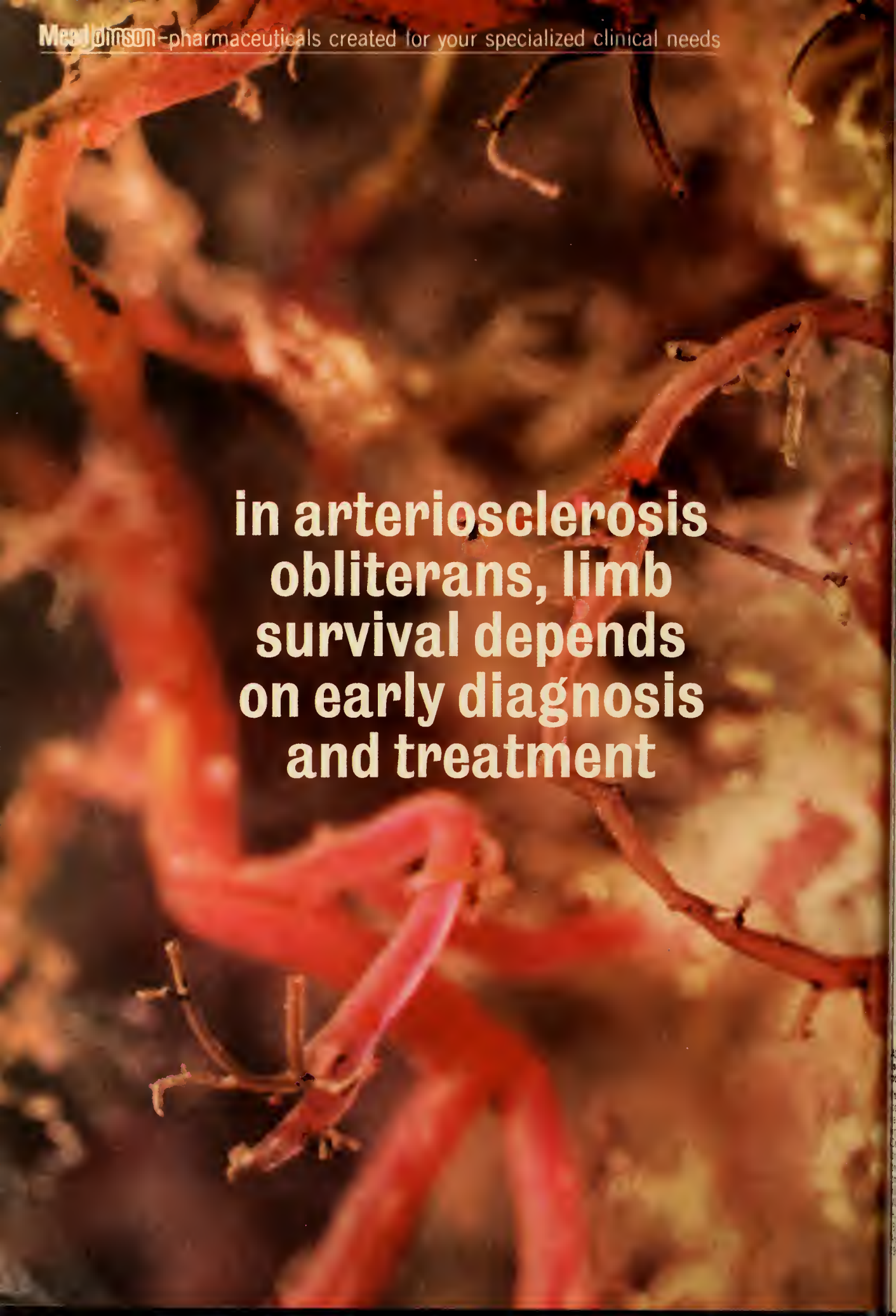
Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.

Dosage and Administration: The maximum total daily dose should not exceed 1.5 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available—Pediatric Injection 75 mg. in 2 ml. A.H.F.S. Category 8:12.28

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KANTREX® INJECTION
(kanamycin sulfate)



in arteriosclerosis obliterans, limb survival depends on early diagnosis and treatment

Microphoto of small artery occlusions in a toe amputated because of severe arteriosclerosis obliterans. Cast was made by injecting acrylic plastic into the vessels. The occluded vessels measure about 30 to 50 microns in diameter. *Used with permission. Courtesy of Margaret C. Conrad, Ph.D., Department of Physiology, Bowman-Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.*

in responsive arteriosclerosis obliterans

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(ISOXSUPRINE HCl)

- **acts directly to increase blood flow to deep muscle arteries**[1-3]
- **improves walking ability, relieves rest pain**[3-5]
- **may be used safely in patients with peptic ulcer, diabetes or chronic coronary artery disease**[3,6,7]

New 20 mg. strength now available: Vasodilan 20 mg. tablets for greater dosage simplicity and convenience. Recommended *initial* dose: one 20 mg. tablet q.i.d.

Although not all clinicians agree on the value of peripheral vasodilators,[8-10] several investigators[3,6] have reported favorably on the effects of isoxsuprine on peripheral blood flow in skeletal muscle vessels. Effects have been demonstrated both by objective measurement[1,6,11] and observation of clinical improvement.[3-5,12]

Indications: Arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Stein, I. D.: Angiology *15*:1 (April) 1964. (2) New Drugs— Evaluated by the A.M.A. Council on Drugs, Chicago, American Medical Association, 1967, pp. 295-297. (3) Kaindl, F.; Pärtan, J., and Polsterer, P.: Wien. klin. Wchnschr. *68*:186-191 (March 16) 1956. (4) Frieh, Ch., and Olivier, L.: Lyon Méd. *91*:891-896 (May 24) 1959. (5) Weghaupt, Von K.: Wien. klin. Wchnschr. *69*:31-32 (Jan. 11) 1957. (6) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, H. E.: Angiology *10*:185-192 (Aug.) 1959. (7) Samuels, S. S., and Shaftel, H. E.: J. Indiana M. A. *54*:1021-1023 (July) 1961. (8) Myers, K. A.: Mod. Treat. *4*:370-383 (March) 1967. (9) Gillespie, J. A.: Angiology *17*:280-288 (May) 1966. (10) Smit, Horne, F., *et al.*: Nord. med. *20*:1260, 1959. (11) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*:142-145 (Sept. 12) 1959. (12) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960.

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adolescents to defer vital decisions regarding life plans and marriage. — W. Godfrey Cobliner, *Bulletin of the New York Academy of Medicine*

Tedium for the Writer, Not for the Reader

"Some years ago, after having served as book review editor for a decade or so, I became chief editor of the *Archives of Internal Medicine.* I made a special effort to see if there were anything innate, any incorrigible stylistic disease, which required a medical paper to be obscure, dry, dull, tedious, and obtuse. It was no discovery that the author of such medical papers had a parent's pride in the offspring. Most would-be writers are offended if substantial corrections are suggested. Very few come to recognize and understand how much improvement may occur if one follows some simple rules of writing, especially if one makes an effort to simplify. Every now and then a physician who writes medical papers will go to much trouble, trying to learn by example and by precept, by diligence and practice, by tedious repetition of rewriting, to produce a clear, simple, and excellent paper."—William B. Bean, M.D., Editor-in-Chief, *Current Medical Digest.*

Qualified Practitioners in the Island Areas

"In the Health Department (in the Cook Islands), we have three levels of medical attendant according to training. These are:

"Fully qualified practitioners with University training;

"Practitioners qualified in the Medical School in Fiji (formerly called Assistant or Native Medical Practitioners);

"Unqualified Medical dressers.

"Fiji qualified medical practitioners provide the major part of the medical services in the islands. They have a five year training course covering all aspects of medicine, surgery and obstetrics with greater emphasis on practical and emergency procedures rather than theoretical considerations. The basic medical subjects are fully covered and diplomas in medicine and surgery granted on completion of study. Practitioners with this qualification are competent and capable of dealing with medical practice in isolated areas with minimum supervision. They can progress to specialist status and we have one surgeon, one physician anesthesiologist, and one public health physician with this qualification but they are only permitted to practice within the territory." — Milo H. Fritz, M.D., in *Alaska Medicine,* quoting the director of health of the Cook Islands.

Putting the Brakes on Runaway Population

"But man's instinctive urge to procreate and the democratic idea that he should be free to do so will die hard. Even the family planners emphasize planned and wanted children rather than smaller families. These attitudes are rapidly becoming a luxury that we can no longer afford. Subtle and not-so-subtle pressures will have to be exerted against those irresponsible individuals who want to breed without limit, and others must at least have easier access to birth control information. Existing methods of birth control must be widely and cheaply available and efforts made to develop safer and more effective methods. Abortions should be made more easily obtainable and compulsory sterilization should be a prerequisite for obtaining public welfare, in some instances." — Warren D. Bowman, Jr., M.D., Montana Scientific Editor for the *Rocky Mountain Medical Journal*

A Lady Bathes a la Guide Book

"With the present permissiveness and the lowering of erotic boundaries in literature, the *Massachusetts Physician* may feel remiss if some similar inclusion did not appear in an edition. Hence this minute description of a fair lady engaged in bathing.

" 'You only want a basin of water, a towel, a rag, and five minutes time. When you get up in the morning, pin a petticoat very loosely at the waist, draw your arms out of the sleeves of your chemise, and let it drop to your waist. Take your rag, well wetted, and slap your head and shoulders, rub your arms and chest, and throw handfuls of water around your ears and back of neck. Then throw your towel across your back and 'saw' it dry. Rub fast until you are quite dry. Put on your chemise sleeves, draw on a night gown to keep from chilling, while you tuck your skirts up under one arm, until you wash and dry one limb; drop that side and do the other side likewise, and be sure that the small of the back and the sides get their full share of rubbing. This done, sit down, dip one foot in the basin, rub and dry it, put on your stocking and shoe, and then wash the other.'

"Sir Ashley Cooper in his *Guide Book* published in 1869 gives us this erotic dream. And he, moreover, goes on to say, 'A daily bath is not only not beneficial, but is injurious.' How little did he realize that he could be showing us a pollution prevention of both mind and water." — Edward J. Sawyer, M.D., Letter to the Editor, *Massachusetts Physician*

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After only one year:

Administered to more people than live in Youngstown and Lima:*



Injectable
Garamycin®
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gentamicin sulfate
injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Youngstown and Lima is 203,000. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Injectable Garamycin®
brand of gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	Less Severe 0.8-1.2 mg./kg. for 7-10 days	Resistant/ Moderately Severe Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	Serious/Life-Threatening up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in dividuals with a history of hypersensitivity or toxic reactions gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxic ity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whe serious infection develops, serum concentrations of the drug m rise, with consequently increased risk of ototoxicity. In these p tients or in those in whom recommended dosage or duration therapy must be exceeded as a life-saving measure, routine stud of kidney function should be performed when possible. These m be supplemented by evaluation of the vestibular and auditory fu tion and measurement of serum concentration of the drug wh feasible. Serum concentrations of gentamicin should be maintain below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to days or be repeated unless required for serious infection not sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injecta may occasionally result in overgrowth of nonsensitive organisms. superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant a mals have not revealed teratogenic or ototoxic effects in the fet GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisa by the physician.

Adverse Reactions: The overall incidence of ototoxicity consider related to treatment with GARAMYCIN Injectable was 2.8 per c (16 of 565 patients). Contributory factors (two or more factors w relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently ceived other potentially ototoxic antibiotics (streptomycin or ka mycin), and 5 were over 60 years of age. Six also had decrea high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients sho increases in BUN that were probably related to treatment w GARAMYCIN Injectable. Of 20 increases probably or possibly rela to treatment, 7 were reversible, 9 occurred in terminal patients, a 4 had no follow-up.

Other adverse reactions associated with treatment were one insta each of urticaria, decreased hematocrit, and reversible depress of granulocytes with normal bone marrow. Other rarely repor and possibly treatment-related adverse reactions were anemia, creased reticulocyte count, rash, purpura, drug fever, hypotens convulsions, twitching, salivation, nausea, vomiting, increased tra aminase activity (SGOT or SGPT), increased serum bilirubin, creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-d vials, for intramuscular administration.

For more complete prescribing details, consult package insert Physicians' Desk Reference. Schering literature is also availa from your Schering Representative or Medical Services Departme Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28



Perry R. Ayres, M.D., Editor

Dear Dr. Ayres:

Some comments on "How Members Rated *The Journal* In Opinion Survey", in the June 1970 issue.

1. You can't please everybody!

2. "*The Journal* should be improved." My reply, if I were Editor would be "Would you like to try?"

3. "More scientific material — less activities. political announcements, etc."

Don't you dare leave out the activities, political announcements and news. How else will I know what is going on in medical affairs in Ohio? I read even the births and deaths.

4. If they want pure science let them read the *New England Journal of Medicine* and if they live in Ohio they should read the *OSMJ* too and learn the facts of life in medicine.

5. The *OSMJ* is alright the way it is and you **can tell them I said so.**

With best wishes,

James L. Fisher, M.D.
Youngstown

Catholics — a Minority in Their Own Hospitals

Perhaps the most notable minority in Catholic hospitals are Catholics themselves, according to Monsignor Harrold A. Murray, director of Health Affairs for the United States Catholic Conference. He reports that of 21,015,589 patients treated last year in the nation's 780 Catholic hospitals, 53 percent of them were non-Catholics. Nearly 200 of these hospitals are in communities where no other hospital exists.

painless intramuscular therapy for calcium deficiencies:

Calphosan®

calcium glycerophosphate, calcium lactate

To bring effective calcium therapy to the patient, Calphosan may be administered intramuscularly . . . without pain, inflammatory reactions, induration or sloughing. Injections twice weekly for a series of 5 to 10 injections are recommended.

Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

Write for free copy of "Calcium: The Ubiquitous and Essential Element" and for samples.

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Cordran® Tape

Flurandrenolide Tape (4 mcg. per sq. cm.)

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Clinical & Scientific Features







VOLUME 66 AUGUST, 1970 NUMBER 8

Symposium on Alcoholism

THIS LITERARY SYMPOSIUM is assembled for the physician and the medical student. It is fervently hoped that a better understanding of the illness alcoholism will result and that a change in response to the patient will follow.

The alcoholic needs genuine professional help. In describing a syndrome with social and economic ramifications, and about which there was much moralizing, Osler said of syphilis: "to know" this illness "is to know medicine." Nearly one century later, can't we substitute the word *alcoholism* for the term *syphilis?* There are striking parallels, particularly in the area of multiple system involvement.

Surely we have passed the stage of debating whether or not alcoholism is an illness. While we have indulged in semantic exercises and discussions as to what specialty the problem belongs, it has reached pandemic proportions. Alcoholism has become a major public issue and is the pressing concern of a community and its physicians.

History will record the impact of alcohol on our lives and on our civilization. Future medical chroniclers will likewise judge our attitudes and responses to the many challenges that alcohol abuse presents.

Articles 1 through 5 were published in the July, 1970 issue of *The Journal.* The symposium is completed in this, the August issue of *The Journal* with articles 6 through 11.

The Guest Editor would like to acknowledge the extensive support received in preparing these issues from *The Ohio State Medical Journal* staff and from my secretary, Madeline Freter. I also want to express my appreciation and profuse thanks to the authors for their contributions.

CHARLES N. HOYT, M.D.
Guest Editor

Outline:

1. The Alcoholism Problem. A Challenge to Medical Leadership by Martin D. Keller, M.D., Professor, Department of Preventive Medicine, The Ohio State University, and Franklin R. Banks, Ph.D., Professor, Department of Preventive Medicine, The Ohio State University.

2. Alcoholism. A Review and Overview of the Problem by Charles N. Hoyt, M.D., Clinical Instructor, Department of Preventive Medicine, The Ohio State University.

3. Is There a Biochemical Lesion in the Disease of Alcoholism? Edward B. Truitt, Jr., Ph.D., Senior Fellow (Pharmacology), Battelle Memorial Institute, Columbus.

4. D.D.T. — The Drinker's Dilemma and Treatment. A Psychiatrist's View by H. T. Goodman, Jr., M.D., Columbus.

5. The Outpatient Treatment of the Alcoholic by Richard E. Bibb, M.D., Assistant Professor of Psychiatry, University of Cincinnati College of Medicine; Associate Director, Central Psychiatric Clinic; and Medical Director, Alcoholism Clinic of Cincinnati.

6. Alcohol and Liver Disease by John Fisher, M.D., Fellow in Gastroenterology, and C. Joseph DeLor, M.D., Professor of Medicine, The Ohio State University College of Medicine.

7. (Limited) Usefulness of Electroencephalography in Alcoholism by Charles E. Henry, Ph.D., Department of Neurology, Cleveland Clinic.

8. Some Remarks on the Physician's Role in the Treatment of Alcoholism by Maurice Victor, M.D., Professor of Neurology, Case Western Reserve University School of Medicine.

9. Rosary Hall. An AA-Oriented Hospital Alcoholic Care Unit by E. Mascarenhas, M.D., Frank R. Hanrahan, M.D., and John J. Plucinsky, M.D., St. Vincent Charity Hospital, Cleveland.

10. Practical Experience with an Alcoholism Program in Industry by William W. Davis, M.D., Medical Director, North American Rockwell Corporation at Columbus.

11. Let's Take Another Look at Alcoholism by Lewis K. Reed, M.D., Youngstown.

Alcohol and Liver Disease

John Fisher, M.D., and C. Joseph DeLor, M.D.

ALCOHOL-ASSOCIATED liver disease is a problem of increasing medical as well as socioeconomic importance. It is a disorder with which most clinicians in medical practice today are called upon to deal. It is not a problem restricted to a small segment of our population, nor is it a problem limited only to the socially outcast alcoholic. It has been shown that at least 65 to 70 percent of our adult population drinks alcohol.*[14] It has also been estimated that alcohol provides 5 to 10 percent of the total caloric intake of the adult American male.[11] However, there are few controlled observations of the incidence and types of alcohol-induced liver disease in various population subgroups. This is an important consideration in view of recent studies indicating that the moderate "social drinker" as well as the established alcoholic may develop abnormal tests of liver function and discrete histopathologic hepatic lesions following ingestion of ethanol.

The Greeks, in the second century B.C., were perhaps the first to recognize that drinking alcoholic beverages in excess is harmful to the liver. Since that time, an association between alcohol and chronic liver disease has been firmly established. The exact nature of this association is still an unsettled question. Whether alcohol per se is directly responsible for the development of cirrhosis or whether other factors such as poor nutrition are necessary, has been a subject of continuing controversy. Recent studies have clarified some questions but left others unanswered. It has been demonstrated that human volunteers consuming "moderate" amounts of alcohol and otherwise normal diets may develop distinct histopathologic changes in the liver.[22] However, the important questions of the significance of these changes, their relationship to impaired liver function, and their relation to the development of Laennec's cirrhosis remain unanswered.

It is the purpose of this paper to review the pathogenesis and varied clinical manifestations of alcohol-induced liver disorders. Attention will be focused on the metabolic effects of ethyl alcohol and the relation of the hepatic abnormalities induced by alcohol to chronic liver disease. It is hoped that a better understanding of the pathogenesis of alcohol-induced liver disease will provide a more rational basis for the diagnosis and treatment of this spectrum of diseases.

Metabolism of Alcohol

A brief review of the metabolism of alcohol and its effect on lipid metabolism is necessary for understanding the mechanisms of alcohol-induced liver disease. Alcohol is rapidly absorbed from the human stomach, small intestine, and colon. About 90 to 98 percent of this absorbed alcohol is completely oxidized in the liver. The remainder is disposed of through the lung and kidneys.[1] Man is capable of metabolizing alcohol at a rate approaching 200 milligrams per kilogram of body weight per hour.[15] This is equivalent to about a "fifth" of 86-proof whiskey per day for an average 70-kilogram man.

The generally accepted pathways in the metabolism and utilization of alcohol by the liver are illustrated in Figure 1. The initial steps in the degradation of alcohol are through oxidative conversion to acetaldehyde and acetate. These reactions are catalyzed by alcohol dehydrogenase, a zinc containing enzyme found in the soluble fraction of liver cells. Nicotinamide adenine dinucleotide (NAD) serves as the cofactor for hydrogen ion transfer in the oxidative processes. Reduced NAD ($NADH_2$) is therefore generated and is reflected by an increase in the intracellular $NADH_2$:NAD ratio. An important role of reduced NAD, resulting from the oxidation of alcohol, is to serve as a cofactor in fatty acid synthesis. In addition, increased amounts of $NADH_2$ facilitate increased hepatic conversion of pyruvate to lactate. This in turn may result in several metabolic

*The terms alcohol and ethanol will be used interchangeably throughout this paper.

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changes such as lactic acidosis, hyperuricemia, and decreased gluconeogenesis.[2]

It has recently been proposed that alcohol dehydrogenase may not be the only major enzyme system responsible for the degradation of alcohol. Rubin and Lieber[13] have suggested that the microsomal fraction of hepatic cells contains a system capable of oxidizing alcohol. They have termed this system "MEOS" which is an abbreviation for microsomal ethanol oxidizing system. The postulate that a system other than alcohol dehydrogenase is capable of oxidizing alcohol is supported by several observations: Alcohol itself induces the enzyme activities of the microsomal fraction, which has a pH optimum in the range of 6.8 to 7.4;[2] Alcohol dehydrogenase has a decidedly unphysiologic pH optimum of 11 and has not been shown to increase in response to alcohol ingestion. The importance of "MEOS" in alcohol metabolism has been questioned by Tephly, Tinelli, and Watkins.[37] They have demonstrated that the microsomal systems are capable of oxidizing only seven percent of the total alcohol metabolized in the rat. Furthermore, these authors found no effect on alcohol oxidation when using, alternately, inhibitors and stimulators of microsomal fractions. The relative importance of "MEOS" and alcohol dehydrogenase in alcohol metabolism remains unknown.

Lipid Metabolism

Administration or ingestion of alcohol may cause significant alterations in lipid metabolism. These changes give rise to fatty metamorphosis of the liver as well as changes in plasma lipids. The effects on plasma lipids principally involve alterations in free fatty acids (FFA) and triglycerides. Lipoprotein synthesis and release by the hepatocyte may also play an important role in the ability of alcohol to alter the transport and utilization of fat.

With the ingestion of large amounts of alcohol, resulting in blood levels of 300 mg. per 100 ml., FFA are markedly increased.[1] But with moderate amounts of alcohol, up to 300 grams per day for 18 days, there has been observed no change in circulating FFA.[10] This latter finding suggests that the mechanism of increased peripheral fat mobilization is not the primary factor in the production of a fatty liver. There appears to be a different effect with regard to serum triglycerides. With ingestion of moderate amounts of alcohol, there is an initial rise in serum triglycerides. However, with continued intake of the same amount of alcohol or with increase of blood alcohol levels, serum triglycerides are shown to fall.[10] The reasons for this are not clear.

The lipid that accumulates in hepatic

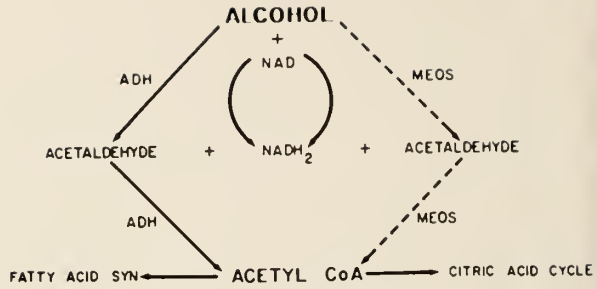


Fig. 1. Pathways in metabolism of alcohol.
ADH = Alcohol Dehydrogenase
MEOS = Microsomal Enzyme Oxidizing System

parenchyma may arise from three possible sources: peripheral adipose tissue stores, dietary fats, and from de novo synthesis by the liver itself. The actual mechanisms of hepatic fat deposition in the alcoholic have not been clearly established. There are probably multiple factors involved. The major mechanisms that have been proposed are: (1) increased peripheral mobilization of nonesterified fatty acids; (2) increased de novo hepatic synthesis of fatty acids; (3) preferential esterification of fatty acids to triglycerides; (4) decreased fatty acid oxidation; and (5) impaired release of low density lipoproteins from the liver. As a result, there is an increased hepatic supply of fatty acids, which can be converted to neutral lipids or triglycerides. It is not within the scope of this paper to review the evidence favoring each mechanism. For a more complete discussion of the effects of alcohol on hepatic fat disposition, the reader is referred to the comprehensive reviews by Isselbacher and Greenberger[1] and Lieber.[7]

Fatty Liver

Many of our concepts concerning the relationships between alcohol, malnutrition, and fatty liver are based on conflicting evidence. In the past, the etiologic importance of malnutrition appeared to be predominant. This was emphasized by the observation that alcoholics suffer from malnutrition. Kwashiorkor, a disease of severe protein deficiency, is also associated with fatty liver. However, present evidence indicates that alcohol itself produces fatty changes in spite of calorically adequate, nutritious, and protein-rich diets. In this regard, Rubin and Lieber[12] have recently stressed the "overemphasized relationship" between malnutrition and liver disease. This will be discussed later.

There is abundant experimental evidence suggesting the etiologic importance of dietary factors in the development of fatty liver in the

alcoholic patient. It has been reported[18] that diets rich in protein are of benefit to alcoholics with liver disease and that the continued use of alcohol is not detrimental when given with adequate diet. In this regard, Summerskill, et al[18] gave malnourished alcoholic patients 90 to 120 ml. of 95 percent ethyl alcohol and a 2200 to 2800 calorie diet. He found no ill effects from alcohol by both chemical and histologic studies and even suggested that alcohol may have some beneficial effects in treating patients with alcoholic liver disease. Patek found similar results.[17] Phillips and others[19] studied three alcoholics treated with alcohol-withdrawl and protein-free diets. They found no functional or histologic improvement. In a second period, these same subjects were given a regular hospital diet containing 80 to 100 grams of protein per day with rapid improvement. Clinical studies such as these combined with the finding of a high incidence of fatty liver in areas endemic with protein malnutrition have suggested that a nutritional etiology in "alcoholic liver disease" is important.

Although dietary factors play an important role in potentiating the development of fatty liver in chronic alcoholics, there is no longer doubt that alcohol itself causes fatty metamorphosis in man. Twenty years ago Klatskin and Yesner[20] demonstrated that, in alcoholic patients with liver disease, there was significant clinical, functional, and histologic improvement with the withdrawl of alcohol, bed rest, and "minimal basic diet" containing one gram of protein per kilogram of body weight. Lieber and others[21] demonstrated in 1965 that alcoholics with morphologically normal livers would develop typical fatty changes with moderate amounts of ingested alcohol and an otherwise normal dietary regimen. The steatosis appeared dependent on both the dose and duration of alcohol intake.

Recently, normal, non-alcoholic human volunteers have been shown to develop fatty livers, proven by liver biopsy, after ingesting moderate amounts of alcohol for short periods.[22] Twelve young subjects, mostly students and all in good health, were studied. Rapid accumulation of hepatic fat and ultrastructural changes were seen in spite of diets containing normal or supplemental amounts of protein. Various quantities of alcohol were consumed which were intended to correlate not with an alcoholic's consumption but with that of an enthusiastic "social drinker." While some subjects consumed 7 to 14 ounces of 86-proof alcohol daily for eight days, others drank 18 ounces each day for two days. Although euphoria and headache were experienced, slurred speech and ataxic gait were absent. Blood alcohol levels usually fluctuated between 20 and 80 mg. per 100 ml. most being about 50 mg. per 100 ml. This is generally below the legal level for alcoholic intoxication in most states of this country.

These studies emphasize the fact that alcohol per se may be hepatotoxic. It can cause histologically proven fat accumulation in the liver. It can cause mitochondrial enlargement and distortion with increase in smooth endoplasmic reticulum. Liver enzymes (SGOT, SGPT) were slightly elevated in 60 percent of those patients studied. These findings were in healthy, young volunteers and thus none of these changes could be ascribed to previous alcoholism or nutritional deficiencies.

The question, which is yet to be answered, is whether the histopathologic findings described above are a true reflection of hepatic toxicity or an expression of normal adaptive processes by the liver. This latter possibility seems unlikely in view of the natural history of alcohol-induced fatty liver. Leevy[29] has shown that persons with this lesion who continue to drink moderate to excessive amounts of alcohol for more than a few years have an increased risk of developing Laennec's cirrhosis. However, there is no conclusive experimental proof that alcohol-induced steatosis is a necessary precursor of fibrosis or cirrhosis in human subjects.

TABLE 1. **Histologic Characteristics of "Alcoholic Hepatitis."**

1.	**Focal liver cell necrosis**
2.	**Parenchymal disorganization**
3.	**Alcoholic hyaline bodies of Mallory**
4.	**Polymorphonuclear leukocyte infiltration**
5.	**Variable amounts of fatty infiltration**
6.	**Variable amounts of fibrosis**

Alcoholic Hepatitis

Alcoholic Hepatitis is a disorder less frequently seen in association with excessive alcohol consumption but which has more serious consequences. The characteristic findings of this lesion are shown in Table 1. Hyaline degeneration (Mallory's alcoholic hyaline), extensive focal necrosis of liver cells and polymorphonuclear leukocyte infiltration are usually present. The presence of steatosis and fibrosis is variable. Although cirrhosis may accompany this disorder, it is not a part of the lesion. Mallory,[26] in 1911, was the first to describe this histologic picture. However, it was not until 1954 that Phillips and Davidson[23] characterized the entire clinical picture of fever, leukocytosis, anorexia, abdominal pain, jaundice and severe impairment of hepatic function. Of the 56 alcoholics studied, 18 died in acute hepatic insufficiency. All showed the characteristic histopathologic picture of alcoholic hepatitis. Lesser degrees of acute cellular disruption were usually associated with less clinical evidence of liver dysfunction and a better prognosis. Although fat and

fibrosis are usually present, the lesion of "alcoholic hepatitis" is distinct from fatty liver and is independent of the amount of fat present.

Popper, et al[24] studied 35 alcoholics in whom they described a similar histologic picture associated with varying amounts of fat and fibrosis. He mislabeled this histopathologic lesion "florid cirrhosis" and speculated that it may be a link between fatty liver and cirrhosis. He, as well as others, have postulated that the liver cell necrosis and parencymal disorganization of "alcoholic hepatitis" may be the critical factors in predisposing to the formation of cirrhosis. It is interesting that electron-microscopic findings[25] of mitochondrial changes in this disorder have paralleled the findings of Rubin and Lieber[22] in their studies of alcoholic-induced fatty liver in non-alcoholic volunteers.

Cirrhosis

It has never been conclusively proven that alcohol alone causes cirrhosis of the liver in humans. It has been shown that, while the incidence of alcoholism is high in cirrhotics,[29] the majority of alcoholics do not develop cirrhosis. The actual incidence of cirrhosis in alcoholics in this country has been estimated at between nine[29] and 29 percent.[28] The factors responsible for whether or not cirrhosis develops in an individual patient are not known. However, in this regard, Lelbach [38, 39] has shown a strong positive correlation between the intensity of alcohol abuse and the severity of histologic liver damage. In a study of 320 alcoholics, he found either normal histology or uncomplicated fatty infiltration in those patients consuming less than 160 grams of alcohol daily. Severe liver damage was found only in those alcoholics admitting to an intake of over 200 grams per day. The duration of alcohol abuse was also significant. Cirrhosis of the liver was found in one out of every four persons with a 12 to 13 year history of alcoholism, and in fully half of those who abused alcohol for at least 22 years. In that report, there was no conclusive evidence that either previous infectious hepatitis or dietary deficiencies had any influence on the severity of the histopathologic changes of the liver.

Although alcohol is known to produce hepatocellular changes such as fatty metamorphosis and "alcoholic hepatitis," the role of these lesions in the development of cirrhosis is not established. A number of other factors have been implicated in the formation of Laennec's cirrhosis. These include starvation, protein or vitamin deficiencies, lack of lipotropic agents (such as choline), congeners of alcohol, and intercurrent infection. The number of names given to the type of cirrhosis seen in chronic alcoholics reflects uncertainty as to the genesis and histopathology of this lesion. They include alcoholic, fatty, Laennec's, portal, micronodular, and nutritional cirrhosis. Even post-necrotic cirrhosis is being seen in alcoholics with increased frequency.[32] The literature is conflicting. This has resulted from lack of good experimental animal models and from the absence of well-controlled, prospective studies in humans.

The belief that fatty liver causes cirrhosis has been a popular one. Yet, fatty liver may be a completely reversible process. Fatty livers seen in other nutritional diseases in man, such as Kwashiorkor, do not lead to cirrhosis.[11] Leevy has studied a group of 50 patients with fatty liver.[29] Of the 25 who stopped drinking, none developed cirrhosis. But of the 25 who continued to drink, two-thirds did develop cirrhosis. The steps leading from fatty liver to cirrhosis remain unknown. MacDonald[31] has postulated that swelling of hepatocytes or Kupffer cells due to fat accumulation leads to obstruction and injury with development of fibrous tissue and ultimately cirrhosis. Popper[30] also studied the relationship of fat to the development of cirrhosis in a series of pathologic specimens. While he noted fat to be a prominent feature, he felt that other factors such as hepatic necrosis may be more important. Galambos[9] has reported on 46 patients with alcoholic hepatitis, 89 percent of whom had persistent disease up to 12 years. Approximately half of these patients developed cirrhosis while the other half continued to have changes of alcoholic hepatitis without evidence of cirrhosis. Galambos also noted the presence of glycosaminoglycans (mucopolysaccharides synthesized by fibroblasts) in the ground substance of patients with alcoholic hepatitis, indicating activity of fibroblasts.[33] These substances have not

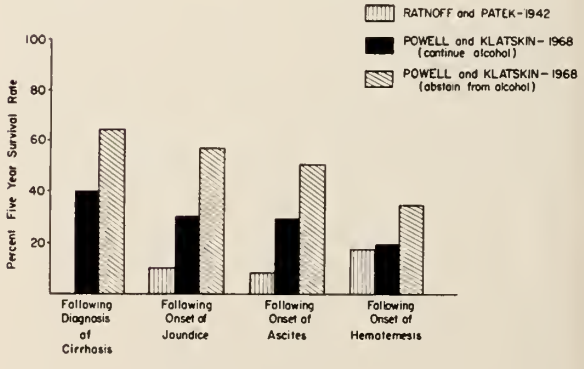


FIG. 2. Comparison of five-year survival rate in patients with Laennec's cirrhosis following onset of various complications. Data derived from reports by Ratnoff and Patek[36] and Powell and Klatskin.[35] Note substantial improvement in survival of patients who abstain from alcohol in comparison to those who continue to drink.

been observed in simple fatty livers. This evidence is interpreted as suggesting an etiologic role of alcohol-induced hepatitis in the formation of cirrhosis.

In *summary*, it appears that although the transition of alcohol-induced fatty liver and alcoholic hepatitis to cirrhosis has been well documented, conclusive evidence that these lesions are causally related to Laennec's cirrhosis is still lacking. Although alcohol is the single factor which is consistently present, its role in the etiology of cirrhosis is not clear. Other factors such as malnutrition, genetic predisposition, and congeners of alcohol, although in themselves have never been shown to cause cirrhosis in man, may be significant in their ability to alter the response of the liver to alcohol.

Prognosis

What is the prognosis of an individual with Laennec's cirrhosis? Will abstinence from alcohol improve life expectancy? These questions have recently been answered in part in a study of 278 alcoholics with biopsy-proven cirrhosis.[35] Comparing their findings with those in the classic study of Laennec's cirrhosis by Ratnoff and Patek,[36] Powell and Klatskin found a much greater five-year survival. Where Ratnoff observed dismal 7 and 10 percent five-year survival rates after the onset of ascites and jaundice respectively, recent findings indicate a three- to six-fold increase in survival depending on whether alcohol is continued or given up. In Powell's total group,[35] the five-year survival rate was 40.5 percent for those who continued to drink alcohol and 63 percent for those who abstained completely. Similar advantages in the survival were noted even after the onset of serious complications such as ascites, jaundice, and hematemasis. Figure 2 illustrates these findings.

Management

Current concepts in the treatment of these disorders have generally reflected lack of knowledge and disagreement over the basic pathogenesis and natural course of alcohol-associated liver disease. Some basic principles of therapy, however, can be applied: continued use of alcohol should be discouraged; basic requirements for calories, proteins, and vitamins must be met; most other agents are of no proven benefit. Table 2 illustrates the useful and nonuseful modes of therapy. Management should be that of therapeutic restraint. Therapy other than alcohol withdrawal and normal diet, unless specific indication, is of questionable value and has not been proven beneficial to man. Although anabolic steroids and glucocorticoids have been shown to be efficacious in isolated instances, they have not proved to be consistently beneficial. At present there are no controlled studies attesting to their efficacy on a long term basis. Experience has shown that with alcohol withdrawal alone, one may offer the patient with (only) fatty metamorphosis complete reversibility of all histopathologic abnormalities and the patient with established cirrhosis a considerable increase in life expectancy.

TABLE 2. **Comparison of the Efficacy of Different Types of Treatment in Alcohol-induced Liver Disease.**

Proven Benefit
1. Withdrawal of alcohol
2. Basic diet (minimum 70 grams protein)
Questionable Benefit
1. Vitamin supplements (unless specific deficit)
2. Fat restricted diet
3. Supplemental calories
4. Lipotropic agents
5. Corticosteroids
6. Anabolic steroids

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The (Limited) Usefulness of Electroencephalography in Alcoholism

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THIS IS NOT a documented and referenced review of the effects of alcohol on the electroencephalogram. Instead, this brief note will deal with the ways in which electroencephalography (EEG) may be useful in problems of alcoholism. More specifically, it will illustrate how the general practitioner and the specialist may use EEG in the evaluation of the patient more or less addicted to drink. It reflects the current experience of a very busy clinical EEG service seeing predominantly organic patients, as well as prior experience with a mainly psychiatric population.

As the title suggests, the EEG is not useful in the diagnosis of alcoholism. Normal records are usually seen even from patients whose intake of alcohol is the equivalent of a fifth of whiskey daily. Since the clinically apparent effects of alcohol so clearly implicate the central nervous system, this may seem surprising. One can only conclude that, except for most prolonged overindulgence, perhaps further associated with nutritional deficiencies, the effects of alcohol are largely functional and reversible. Experiments have shown that in acute ingestion the initial effect of alcohol on the EEG is mild slowing of the basic physiologic rhythms. Increasing amounts of alcohol cause further slowing and disorganization, the changes at any point being related to blood alcohol level.

We are more interested in the effects of chronic alcoholism. The most common reason for

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referral of such patients to the EEG laboratory is the occurrence of convulsive seizures. All too often there is no good description of such apparent "rum fits." They occur in an age range where the possibility of brain tumor must always be considered. Full EEG study, which means minimal complement of 21 electrodes, photic stimulation, and vigorous hyperventilation, plus a sleep recording, is the most economic and least traumatic way to rule out the probability of such a complication.

Because such fits tend to occur after prolonged alcoholism, and often in association with delirium tremens, some degree of EEG abnormality may be found. Only rarely is this of a specifically epileptiform character. Postictal changes often complicate evaluation. Known or occult head injury is another hazard, and persistent differences in background activity, with or without associated slowing, may suggest the unexpected possibility of subdural hematoma. Serial or repeat EEG study is advisable.

Understandably, some epileptic patients become alcoholics. This compromises the control of seizures by anticonvulsant drug therapy; complications are further increased when such treatment is neglected while drinking. The catastrophic potentials of driving are obvious. Reinstatement of drug therapy must proceed with whatever treatment is given for alcoholism.

Dr. M. Victor deals elsewhere in this symposium with the pathologic effects of alcohol on the nervous system. Among his fundamental contributions is the verification of the old observation that, just as with other drugs (notably the barbiturates), seizures tend to occur after a brief period of abstinence. For most patients, this was between 7 and 36 hours after the last drink. Although the resting EEG was not particularly remarkable, about half of such patients displayed an increased sensitivity to high intensity intermittent photic stimulation. Even patients without prior seizures but with other abstinence signs, including delirium tremens, showed a pronounced increased sensitivity to such photic stimulation, often persisting for many hours. Thus, it is important to include such activation procedures as part of the EEG investigation. Indeed, in view of the ease and brief time involved, it should be used with all patients.

The referring physician must bear in mind that the immediately postictal EEG may show transient overall reduction and disruption of physiologic rhythms. Lateralized changes may reflect a (predominantly) lateralized seizure or associated head injury. Thus, unless serial study is desired, it may be preferable to wait a few days before EEG is requested. The clinical significance of such changes may then be assessed more confidently. If the alcoholic fit is not followed by full recovery and if there is persistent or progressive EEG abnormality, it is possible that alcohol may have been a misleading element, which has camouflaged an organic lesion. More careful neurologic evaluation will be needed for such patients.

Chronic alcoholics run a markedly increased risk of liver disease. Patients with Laennec's cirrhosis may show, especially with serial EEG study, a quasi-specific EEG abnormality. This is the pattern of triphasic spiking seen bilaterally at high voltage from the frontal regions. Patients in hepatic coma, of whatever etiology, show a pronounced EEG abnormality which increases with the degree of coma. Generally, diffuse 4 to 7 cycles per second theta activity precedes the stage of triphasic spiking, which in turn may be replaced by more diffuse polyrhythmic slower delta activity. Cerebral changes are secondary to the more fundamental metabolic disturbance. They correlate well with depth of coma but less closely with the level of blood ammonia, presumed to be the toxic substance.

The EEG may occasionally yield reassuring information, such as the normal deep sleep record from a near-unresponsive teen-ager found after experimenting with the effects of alcohol. In contrast, an abundance of rhythmic fast activity would make one suspect other drug effects, particularly the barbiturates. EEG study may thus be useful for rapid evaluation of unresponsive patients.

In *summary*, the chronic alcoholic, free of focal neurologic signs referable to the brain is likely to have an unremarkable EEG. Abnormal EEGs are common in the acute withdrawal stages, but even the activated discharges elicited by stroboscopic stimulation are *not* indicative of epilepsy. A rum fit should not trigger an EEG requisition, but, if an EEG is requested, the physician should make available the full clinical details. Negative EEG findings may have some reassuring value; conversely, clear abnormality raises the distinct probability of concurrent disease or trauma. When the EEG abnormality is generalized, it is likely to reflect a metabolic disturbance, most often secondary to liver damage; if focal, it raises the possibility of unrelated brain disease.

Some Remarks on the Physician's Role in the Treatment of Alcoholism

Maurice Victor, M.D.

IT IS ESTIMATED that there are, in the United States, between five and six million alcoholics, i.e., individuals whose dependence upon alcohol has reached such proportions that it has injured their health and seriously interfered with their interpersonal relationships and their social and economic function. It requires little imagination to conceive the havoc wrought by alcohol in terms of economic loss, automobile accidents, crime, mental and physical disease, and disruption of family life. Judged in these terms, alcoholism must represent the gravest community health problem in this country.

The problems created by excessive drinking are difficult to manage, as every physician knows. The patient's immediate need may be for treatment of a medical or surgical illness or for the services of a psychiatrist or social agency, but eventually one must confront the basic psychologic problem — what it is that impels the patient to drink excessively, often with full knowledge that such action will result in physical injury to himself and irreparable damage to his family. The complexity of this problem and the fact that it is frequently nonmedical in nature are to a large extent responsible for the reluctance of most physicians to involve themselves with alcoholics. There are other reasons as well. Many physicians are under the impression that it is impossible to alter the drinking tendency once it has become established so that efforts on behalf of the alcoholic are wasted, and others cling to a moralistic view that the alcoholic is to blame for his illness and therefore undeserving of the physician's time and efforts.

If any significant impact is to be made on the problem of alcoholism, it is essential that physicians take more responsibility for its management than they have until now. Actually, the physician is in a particularly favorable position to fulfill such a role. He may have seen the patient through a medical or neurologic complication of alcoholism, a most propitious time to initiate treatment of the drinking problem. The early manifestations of alcoholism frequently present in the guise of medical symptoms so that the physician has the opportunity of detecting the disease in its early stages and perhaps modifying its evolution. And patients with a drinking problem are often willing to consult a physician at a time when they are unwilling to accept help from other sources.

There are many misconceptions about alcoholism that have served to deter the physician from becoming involved with this problem. In this brief communication, an attempt will be made to dispel some of these misconceptions and to consider certain principles of treatment that have proved to be useful in the management of alcoholism and its complications.

The Medical and Neurologic Complications of Alcoholism

The pathologic effects of alcohol are mainly on the gastrointestinal and nervous systems. Little need be said here about the former insofar as the treatment of gastritis, peptic ulcer, pancreatitis, cirrhosis of the liver and its complications are much the same in the alcoholic as in the nonalcoholic patient. With respect to the neurologic complications of alcoholism, however, there is considerable confusion. In most of the writings on this subject, no clear distinction is made between alcohol addiction, acute intoxication, mild withdrawal symptoms, delirium tremens, and even Korsakoff's psychosis and polyneuritis. Although the abuse of alcohol underlies all of these disorders, the mechanism by which alcohol produces its effects is quite different from one to another; it follows that the various complications of alcoholism should not be treated as a single disease.

Alcohol Intoxication

The most common effects of alcohol on the nervous system are those of *intoxication* — ex-

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hilaration and excitement, loss of restraint, loquacity, slurred speech, irritability, incoordination of movement and gait, drowsiness, and, in advanced cases, stupor and coma. These symptoms are the result of the depressant action of alcohol on the central nervous system, acting in a manner akin to the general anesthetics. Unlike the inhalation anesthetics, the margin between the dose of alcohol that produces surgical anesthesia and that which dangerously depresses respiration is small, a fact that accounts for occasional fatalities in cases of severe alcohol intoxication.

Mild or even moderately severe degrees of alcohol intoxication are usually of short duration; if the vital signs are normal, no special therapeutic measures are necessary. On the other hand, severe depression of the state of consciousness (coma) due to alcohol intoxication is a medical emergency, the great danger being death from respiratory depression. The main object of treatment in these cases is to tide the patient over the crisis in respiration, using mechanical aids such as an automatic, positive-pressure respirator, if necessary. It should be emphasized that for all practical purposes alcohol is oxidized at a constant rate, regardless of its concentration in the tissues and that, despite many claims to the contrary, there are no drugs or other agents that effectively accelerate the metabolism of alcohol.

Alcohol Withdrawal Syndrome

The commonest cause for the admission of an alcoholic to the hospital is a *syndrome comprised of tremulousness, hallucinosis, seizures, and delirium.* Each of these manifestations may occur in relatively pure form, but far more often they occur in combination with one another. This syndrome invariably occurs on a background of severe and sustained inebriation but only after a period of relative or absolute abstinence from alcohol—hence the designation *"abstinence or withdrawal syndrome."*

With respect to prognosis and treatment, it is important to distinguish between the mild and severe symptoms of alcohol withdrawal. The former, comprising tremor, restlessness, insomnia, anorexia, and, less commonly, hallucinations and seizures, begins as early as seven to eight hours after the withdrawal of alcohol and reaches its peak of intensity within 24 hours; these symptoms are invariably benign. A second group of symptoms is characterized by profound confusion, vivid hallucinations, psychomotor and autonomic nervous system overactivity in the form of tachycardia, sweating, and fever; this is the major syndrome, or delirium tremens, which has its onset later in the withdrawal phase, usually 48 to 72 hours after cessation of drinking, and it is a serious threat to life, ending fatally in 5 to 15 percent of cases.

Treatment of the Alcohol Withdrawal Syndrome

A variety of drugs has proved to be effective in controlling mild withdrawal symptoms. Some of the more popular agents are prochlorperazine (Compazine), chlorpromazine (Thorazine), promazine (Sparine), and chlordiazepoxide (Librium). Of these, chlordiazepoxide is the safest; the phenothiazines should probably not be used at all because of their epileptogenic properties and other serious side effects. Actually none of these drugs offers any significant advantages over paraldehyde, providing it is freshly prepared and given by mouth. Despite the symptomatic relief afforded by these drugs and their ability to provide rest and sleep, it is not clear that they have the capacity to shorten the duration of the withdrawal symptoms; nor are there any critical data to show that the administration of any of these drugs, in the early phase of the withdrawal period, can prevent the onset of delirium tremens, shorten its duration, or alter the mortality from this disorder.

All of the aforementioned drugs have only a limited usefulness in the management of fully developed delirium tremens. In the latter case, one's object is not the absolute suppression of agitation and tremor; to accomplish this may require an amount of drug that could seriously depress the patient's respiration. The purpose of medication in patients with delirium tremens is to blunt the psychomotor activity so that exhaustion is lessened and medical and nursing care are facilitated.

The most important aspects of the treatment of delirium tremens are the administration of fluids and the correction of electrolyte depletion, particularly of sodium, potassium, and magnesium. The severe agitation and perspiration may require 6,000 ml. of fluid daily, of which 1,500 ml. should be normal saline. The most ominous developments in delirium tremens are peripheral circulatory collapse and hyperthermia. In the former case, one must use blood transfusions and vasopressor drugs, as with shock from any other cause. Hyperthermia demands the use of a cooling mattress in addition to the specific measures for the treatment of any infection that may be present.

Adrenal cortical steroids have no place in the treatment of the withdrawal syndrome. Not only do the steroids fail to alter significantly the course and duration of the abstinence syndrome, but also they have many serious disadvantages, such as masking infection, a deleterious effect on tuberculosis and bleeding ulcers or other sources of hemorrhage, and a tendency to produce a negative nitrogen balance and excessive excretion of potassium. These complications of steroid therapy are all of more than theoretical interest in the alcoholic patient.

The type of epilepsy which occurs only in the

withdrawal period ("rum fits") rarely calls for the use of anticonvulsant medication. In this setting the entire convulsive episode consists of a single seizure, or a brief flurry of seizures occurring over a period of several hours, so that in most cases the seizures have ceased by the time the patient is seen by the physician or by the time that certain medicines, such as Dilantin, become effective. The parenteral administration of sodium luminal in the early stages of withdrawal might be expected to prevent "rum fits," particularly in patients with a history of seizures during a previous episode of alcohol withdrawal. Once the symptoms of withdrawal have subsided, the long-term administration of anticonvulsant medications is not practical, since seizures will not recur if the patient remains abstinent; if drinking is resumed the patient usually abandons his medication.

Very rarely, in the withdrawal period, the patient develops recurrent seizures without regaining consciousness between seizures *(status epilepticus)*, and such cases should be treated like *status* of any other type. In these cases, the intravenous administration of diazepam (Valium) has proved effective.

It should be borne in mind that there are alcoholic patients in whom recurrent seizures (idiopathic or post-traumatic) preceded the onset of alcoholism. In such patients, even a brief episode of alcoholic intoxication may precipitate seizures. These patients should be discouraged from using alcohol in all but the smallest amounts and should, of course, be maintained on their usual anticonvulsant drugs.

The Management of Alcohol Addiction

It is manifestly impossible, within the confines of this brief review, to discuss the numerous theories of the causation of alcoholism and the different forms of treatment that are based on these theories. Alcoholism has been attributed to endocrine or other biochemical abnormalities, vitamin deficiencies, a biologic predisposition, special types of personality structure, or racial and socioracial factors, not to mention the many psychoanalytic formulations. The multiplicity of theories in itself suggests that no single one of them adequately explains why certain individuals become alcoholics. Certainly there is no conclusive evidence that a particular form of therapy, based on any one of these theories, accomplishes more than another.

These comments, which acknowledge the fact that the treatment of alcoholism is difficult, should not be taken to mean that it is hopeless. Such an attitude is unjustified, as the following discussion will make clear. It is also a common misconception among physicians that specialized training in psychiatry and an inordinately large amount of time is required to deal with the addictive drinker. Actually, a successful program of treatment can be initiated by any physician with an interest in this problem, using the standard technics of history-taking, establishing rapport with the patient, and seeing the patient frequently, though not necessarily for prolonged periods. A useful point at which to undertake this task is during convalescence of the patient from a serious medical or neurologic complication of alcoholism or in relation to loss of employment, arrest, or threatened divorce. Such a crisis may help convince the patient, better than any argument presented by family or physician, that his alcoholism has attained serious proportions and that his drinking does indeed constitute a serious problem.

A number of premises about alcoholism and the alcoholic are generally accepted as prerequisites for successful treatment. The most important is total abstinence from alcohol, and for all practical purposes, this also represents the only permanent solution to the problem. It is agreed by all who deal with the alcoholic that any attempts to curb the drinking habit will fail if the patient continues to drink. There are patients who have been able to reduce their intake of alcohol and eventually to drink in moderation, but such instances must be extremely rare.

A number of other common notions about the treatment of alcoholism require qualification. It has been stated frequently that the patient must recognize that he is an alcoholic, i.e., that his drinking is beyond his control, and he must express willingness to be helped. Undoubtedly there is truth in both of these statements, but they should not be interpreted to mean that the patient must gain this recognition and willingness entirely on his own initiative and that he will be helped only after he does so. Actually, the physician, or, for that matter, any other interested person, can do a great deal to help the patient understand the nature of his problem and thus to motivate him to accept treatment. Every device of logic and reasoning must be used to convince the patient that abstinence is preferable to chronic inebriety. The patient must be made fully aware of the medical and social consequences of continued drinking and must also be made to understand that because of some constitutional peculiarity (it is useful to draw an analogy to the diabetic who cannot handle sugar), he is incapable of drinking in moderation. These facts should be presented in a simple and forthright manner, in much the same way as one would explain the essential features of any other disease. There is nothing to be gained from adopting a punitive or moralizing attitude; but there is also no point in giving the patient the idea that he is completely blameless for his illness. There appears to be an advantage in making the

patient feel that he is responsible for doing something about his drinking.

The prevalent belief that an alcoholic will not stop drinking under duress also requires qualification. In fact, the few careful studies on this matter have disclosed that relatively few patients would have sought help unless pressure had been exerted by family or employer; furthermore, patients who came to the clinic under duress of this sort did just as well as those who came voluntarily.

If an earnest and sustained effort by the physician fails to convince the patient that alcohol offers a problem, it is usually impossible to modify his alcoholic tendency. The only way to make such an individual discontinue drinking is to commit him to a psychiatric hospital or special institution for the management of alcoholism in the hope that with forced abstinence and improvement in his physical state he will gain insight and later accept psychiatric or other forms of therapy.

On the other hand, if the patient comes to realize that his drinking is beyond control and that he needs to do something about it, his chances of being helped are considerable. Indeed, under these circumstances, many individuals stop drinking of their own volition. Some of these patients, despite the best of intentions, will relapse; this should not serve as an excuse to abandon the therapeutic program. There are many examples of patients who have attained a state of prolonged sobriety after several false starts. A number of methods have proved valuable in the long-term management of these patients, the most important of which are the use of Antabuse and the participation in social organizations for combating alcoholism.

Antabuse (tetraethylthiuram disulfide, Disulfiram) interferes with the metabolism of alcohol so that a patient who takes both alcohol and Antabuse accumulates an inordinate amount of acetaldehyde in the tissues, resulting in nausea, vomiting, and hypotension, sometimes pronounced in degree. It is no longer considered necessary to demonstrate these effects to the patient; it is sufficient to warn him of the severe reactions that may result if he drinks while he has the drug in his body. Treatment with Antabuse is instituted only after the patient has been sober for several days, preferably longer, and should never be given to patients with cardiac or liver disease. The drug is taken each morning in a dose of 0.5 gm., under supervision if possible. This form of treatment is of particular value in the spree or periodic drinker, in whom relapse from abstinence usually represents an impulsive rather than a carefully planned or premeditated act. The patient taking Antabuse, aware of the danger of mixing liquor and the drug, is "protected" against the impulse to drink, and this protection can be renewed every 24 hours by the simple expedient of taking a pill. The willingness with which the patient accepts this form of treatment serves as a rough index of his motivation. Should the patient drink when he is taking Antabuse, the ensuing reaction is usually severe enough to require medical attention and a protracted spree can thus be prevented.

Alcoholics Anonymous (AA), an informal fellowship of former alcoholics, has proved to be the single, most effective force in the rehabilitation of alcoholic patients. The philosophy of this organization is embodied in their so-called "twelve steps," a series of propositions about alcohol and alcoholism which guide the patient to recovery. The AA philosophy stresses in particular the practice of making restitution, the necessity to help other alcoholics, trust in God, the group confessional, and the belief that the alcoholic is powerless over alcohol. AA philosophy also embodies the 24-hour plan, in which the alcoholic strives for one day of abstinence at a time (a concept inspired by the Sermon on the Mount) as a means of facilitating the maintenance of sobriety. Although accurate statistics are lacking, it is stated that about 40 percent of members who express more than a passing interest in the program have no relapses and that a significant additional number relapse but eventually recover.

The methods used by AA are not suited to every patient, and some prefer the more personalized approach offered by special clinics and centers for the treatment of alcoholism. The physician should, therefore, be fully aware of all the community resources available for the management of this problem, and he should be prepared to take advantage of them in appropriate cases.

Finally, it should be stressed that alcoholism is frequently associated with psychiatric disease of other type. There are data that indicate an increased frequency among alcoholics of schizophrenia, psychoneurosis, sociopathy, and particularly of manic-depressive disease. In the latter circumstance, the prevailing mood disturbance is far more often one of depression than of mania, and this is more prominent in women than in men alcoholics. Obviously the presence of concomitant or pre-existing psychiatric disease will complicate and modify the management of the alcoholic problem and it is in these situations that expert psychiatric consultation should be sought.

Generic and Trade Names of Drugs

Prochlorperazine — Compazine (Smith Kline & French)
Chlorpromazine — Thorazine (Smith Kline & French)
Promazine — Sparine (Wyeth)
Chlordiazepoxide — Librium (Roche)
Diphenylhydantoin — Dilantin (Parke-Davis)
Diazepam — Valium (Roche)
Tetraethylthiuram disulfide — Antabuse (Ayerst)

Rosary Hall
An AA-Oriented Hospital Alcoholic Care Unit

E. Mascarenhas, M.D., Frank R. Hanrahan, M.D., and John J. Plucinsky, M.D.

A REVIEW of this symposium, shows the significant advances made in recent years in understanding the biochemical, physiologic, psychologic, and pathologic effects of chronic alcoholism. However, no significant inroads have been made in treating and rehabilitating the chronic alcoholic. Even though the therapeutic armamentarium of the physician has been strengthened recently with more effective agents to treat acute alcoholic intoxication and withdrawal, the drug therapy of chronic alcoholism remains relatively impotent. A major reason for our therapeutic inadequacy lies, perhaps, in incomplete evaluation of the emotional, physical, and social aspects of the alcoholic.

It was realized at St. Vincent Charity Hospital, Cleveland, in 1952 that these parameters could not be adequately evaluated in either the physician's office, the alcoholic clinic, or the general hospital floor. This, in turn, gave birth to a separate Alcoholics Anonymous oriented unit in the hospital for the care of the alcoholic. Sister Ignatia, C.S.A., came from St. Thomas Hospital, Akron, in 1952 to assume direction of the unit, which was named Rosary Hall.

The purpose of this paper is to show the structure and successful functioning of this mode of organized therapy, which enlists the aid of medical, para-medical, and lay personnel.

Rosary Hall is our well furnished alcoholic care unit, which provides accommodations for 23 male and 7 female patients. The floor is comprised of a recreation room, visiting room, dining room, nursing station, conference room, chapel, and office space for the director and staff. Rosary Hall is staffed by a full-time director acting as administrator and three full-time counsellors and three part-time physicians plus a rotating medical house staff for emergency care. The number of paramedical personnel is less than the requirements on a hospital floor of comparable size, as the demand for special nursing and equipment is minimal. All personnel involved in direct or indirect care of the patient are oriented in the problem of chronic alcoholism. They maintain a sound knowledge and an optimistic view toward recovery.

Admission and Discharge Policy: Alcoholics are admitted to Rosary Hall through the joint efforts of both sponsor and co-sponsor, who must be members in good standing of Alcoholics Anonymous for a period of at least 12 months and 3 months, respectively. Patients referred to us by physicians, social workers, and the clergy are assigned sponsors.

The term of hospitalization is dependent on the assessment of the physical and emotional state of the patient as judged by the physician and program director. The minimum length of stay is ten days, the shortest time interval in which detoxification, education, and rehabilitative measures can be satisfactorily accomplished.

Management: During the period of detoxification, all patients are assessed after admission by one of the physicians with a two-fold objective: (A) to get the patient sober as quickly as possible with a minimum of discomfort: and (B) to uncover any intercurrent psychiatric or medical illness. Careful attention is paid to the state of hydration and nutrition. Dehydration is promptly corrected and an adequate caloric intake along with additional nutritional supplements are provided. Withdrawal is achieved by administering hydroxyzine (Vistaril). As this pyschotropic agent provides the desired sedation, permits early withdrawal, is not hepatoxic or habit forming, and does not compromise cardiovascular status. The dose of Vistaril (range 75 to 400 mg. per day) and route of administration are dependent on the severity of symptoms.

Alcohol is given to more severe cases and withdrawn along with Vistaril. Chloral hydrate is initially given at bedtime to promote sleep. Thiamine hydrochloride, 100 mg. intramuscularly for

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three days, is administered to prevent Wernickes encephalopathy. Dilantin Sodium, 100 mg. four times a day, is given on an empirical basis to diminish seizure activity.

It has been shown that chronic alcoholics with poor nutritional status are apt to have magnesium deficiency.[1] This has been related to excessive neuromuscular irritability.[2] On this basis, we give 2 cc. of 50 percent magnesium sulphate intramuscularly every 8 hours, for the first two days as replenishment. After this period the patient is generally able to eat a normal diet which then provides the daily magnesium requirement. Antibiotics are not routinely administered, but in the event of infection, aggressive therapy is instituted. Every effort is made promptly to discontinue all psychotropic and sedating drugs as it is undesirable to imprison the patient in a new chemical environment.

A routine hematologic and biochemical investigation is carried out along with a chest X-ray and electrocardiogram. Full advantage of the hospital facilities is taken for patients in need of specialized care. A thorough medical examination has helped uncover many medical illnesses ameanable to timely therapy, notably liver impairment, peptic ulcer, diabetes mellitis, chronic bronchitis, emphysema, decompensated cardiac status, psychosis, personality disorders, hematologic abnormalities, and nutritional deficiencies. Prior to discharge from Rosary Hall, the patient is informed of the nature of any existing ailments, therapy is outlined, and further management is placed in the hands of his family physician.

Emotional and Social Evaluation: After detoxification is achieved (average three days), the patient is individually evaluated at length by the program director and counsellors. The emotional and social components of alcoholism are assessed while the patient talks about himself. Accordingly, a plan is outlined to correct any existing personality inadequacies and social or environmental problems. This may entail the cooperation of members of the family, an employer, or friends, who are contacted by the sponsor.

Group Instructions: A systematic one-week instruction program consisting of three classes a day, is given by the staff and other voluntary Alcoholics Anonymous members from all walks of life. The instructions help educate the alcoholic in the nature of mental, physical, and social implications of alcoholism. Frequent informal seminars are held between meetings giving the patient an opportunity to identify himself with his illness and to accept the fact that he must adjust his life to new and learned methods in order to cope with his tension and loneliness. During his stay in Rosary Hall, the Twelve Steps of the Alcoholics Anonymous program are thoroughly explained to the patient. He is urged to join the organization and actively to participate in its activities, since it offers a good line of communication, rewarding projects and activities, a sense of belonging, constant advice, and understanding assistance — all needed for a permanent recovery.

Follow-up: On discharge, the patient is informed of the state of his health. He is urged to join Alcoholics Anonymous and to attend the weekly meetings. His sponsor continues to be deeply interested in his welfare and follows his progress.

Comments

As Chafetz[3], has rightly pointed out, treatment of acute alcohol withdrawal or intoxication without therapy or rehabilitation of the chronic alcoholic state constitutes the poorest form of "half practice" and the height of therapeutic folly. At Rosary Hall, we have attempted to provide a system of total care of the alcoholic. The experience gained over the last 17 years convinces us that these patients should be treated in a special treatment facility and the ensuing comments will be directed toward this end.

Numerous workers have commented upon the personality traits,[4] in the alcoholic, among which fear, hostility, and egocentricity are perhaps the greatest barriers to successful therapy. Possibly the greatest of these fears is that of abstinence reaction. He remembers vividly the last horrifying attempt at abstinence. He fears institutions and stigma-ridden labels and therapy, which to him consist of aversion methods. All these fears are allayed by his sponsor prior to his admission. On arrival in the unit, contact with an amiable competent staff and encouraging fellowmen helps foster reassurance. This self-reassurance, along with the keen desire to abstain, makes him cooperative, a vital factor in rehabilitation. We have been impressed by the relative ease and rapidity with which withdrawal is achieved and by the subsequent behavior pattern of patients at Rosary Hall in contrast to similar individuals treated on general hospital floors. Since therapy is essentially the same in both instances, we attribute this success to a difference in patient and staff attitude.

It is well known that strong negative attitudes prevail amongst people toward individuals, who over-indulge in alcohol. That these conscious and unconscious negative attitudes contribute significantly to therapeutic failure has been shown by Selzer.[5] Mogar, et al[6] have pointed to the varying attitudes of professional and non-professional staff and concluded that as a rule the general hospital staff take a moralistic and pessimistic view of the alcoholic patient. In contrast, both the professional and non-professional staff partaking in constant care of the alcoholic maintain a disease-oriented and optimistic view of

recovery, such as exists in our unit. This is soon appreciated by the patient through contact with the staff and by lectures. This attitude helps enhance recovery.

It has been shown that for treatment success a concensus should exist "between the kind of help the patient desires and the kind of help the therapist is able to provide."[7] Most alcoholics desire "total care," encompassing emotional, social, environmental, and medical aspects of the disease. Admittedly, the family physician is best equipped to treat and counsel his alcoholic patients, but due to the lack of time, the rapidly changing system of medicine, and multiple specializations, an alcoholic's underlying problem may remain untreated or may be met with severe approbation.

The presence of an alcoholic unit at St. Vincent Charity Hospital has proved to be a great help to the doctor and his patient. At Rosary Hall our attempt at "optimal care" has been realized, largely because of its intimate association with "Alcoholics Anonymous."[8]

This remarkable organization with over 7,000 chapters all over the world has contributed immensely to our understanding of alcoholism. Its principles form the basis of our orientation and help the individual to identify himself, accept his disease, correct his disability, build character, restore family unity, and face the future. It presently ranks as the best available follow-up system.

In this era of highly specialized therapy, with the existence in almost all hospitals of a CCU, ICU, and RCU, the presence of an Alcoholic Care Unit remains conspicuous by its absence. Is it not time that a disease, which has remained unthwarted through the centuries, currently afflicting over five million citizens, and possessed of far-reaching moral, social, and economic implications greater than any other disease, be placed in a more realistic perspective? The functioning of such a unit is not beyond the scope or budget of any hospital —its sole equipment is a team of knowledgeable, dedicated workers.

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Generic and Trade Names of Drugs

Hydroxyzine—Vistaril (Pfizer)
Sodium diphenylhydantoin — Dilantin (Parke-Davis)

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Practical Experience with an Alcoholism Program in Industry

William W. Davis, M.D.

ALCOHOLISM in the occupational milieu is not receiving the attention it should. Gradually, management is beginning to realize that every type of organization has this problem. So far, there has been a great reluctance to face the problem and to do something concrete. There are a few outstanding examples of large companies that have taken a positive approach, and they are all exceedingly well pleased with the results.

Realizing that approximately six percent of any working force is being adversely affected by alcohol is fundamental in approaching the problem. Alcoholism steals profits and destroys the men who make the profits. Too often it is erroneously

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assumed that only the lower wage earner is subject to this disease. The six percent involvement is throughout the organization chart, from top to bottom. Industry's estimated "4 billion dollar headache" from alcoholism is produced by faulty management decisions, impaired and reduced productivity, frequent accidents, excessive absenteeism, and loss of company prestige in the public eye.

Before a program for the proper care of the alcoholic in industry can be started, top management must be in agreement. Fortunately, management usually has had personal knowledge of the price alcohol exerts on the individual. Consequently, when given more statistics and the assurance that the savings will be far greater than the cost of a program, management will usually adopt an "OK, but show me" attitude. It is absolutely essential that the employees know that any program has the support of top management.

The program will be best received if it is directed through medical personnel. Thorough grounding of the personnel is essential. Appointment as counselor of a long-time employee who has also been sobered through Alcoholics Anonymous will expedite the program. The counselor's activities can be either partially in lieu of his regular activities or on a full-time basis, depending on the size of the company. The counselor should have a private office in the medical department area. Supervision must be thoroughly informed of the problem and aware of the importance of their support for the success of the program. The instruction to supervision should be in detail by medical personnel. Actual operation of a program will depend on the facilities existing in the community, the ideas of the medical participants, insurance coverage available, and the activity of the alcoholic counselor.

Actual experiences in a large prime airframe producer with an average employment of 10,000 were most dramatic. Initially it was felt the alcoholic counselor could be used only part time from his regular duties. The load developed so fast and his duties were so vital that, in order to give him maximum support and flexibility, he was given this as his only requirement. The company's recognition of a program was announced in the plant newspaper and various instructional handouts were placed conveniently for informing the personnel of the help provided. In the seven years of operation, 340 cases have been interviewed and counseled. Records on these cases are maintained by the counselor on a confidential basis. Continuing follow-up indicates that 220 of these are "controlled or recovered," 75 have had several relapses of varying degrees but are still employable, 45 have refused help and in many instances are no longer employable. No employee was terminated solely because he was an "alcoholic." The alcoholism in this group frequently caused sufficient divergence from acceptable work practices that the employee was terminated for those reasons. There have been six known deaths directly attributable to the effects of alcohol in all groups served.

Initial contact was made by many sources: (A) recognition of the alcoholic by medical personnel when seen in the medical section for other reasons; (B) referred by supervision; (C) brought to the program by a controlled alcoholic buddy; (D) voluntarily seeking help; (E) tip-off from family who knew of plant program; and (F) referral by local courts who knew of the program and sought our support. Soon after contact, intensive interviewing is done. Considerable pressure is brought to bear on the individual to get in the program. Often, incorporation in the Alcoholics Anonymous program is all that is necessary. Some employees are sick enough that they are immediately hospitalized for about ten days in institutions with specialized care for this illness. Others are placed on treatment with Antabuse (disulfiram), administered daily by medical personnel on the employee's own time. All efforts are made to individualize the care received. Financial help, religious support, and psychiatric clinics are frequently interwoven in the care. Our group grew very rapidly, and they decided to have their own Alcoholic Anonymous meetings on "off site" but company property. These meetings consist of about 50 percent plant personnel and the balance are non-employees.

The results of the program have been very gratifying. A concrete example of the effect of achieving sobriety can be gained by study of the absence records of those participating in the program. The work attendance record of a large group, comparing absenteeism for one year prior to coming in the program to one year subsequently, shows the average lost time per employee was cut from three days per month to 3¾ hours per month, a savings of 84.4 percent. It is calculated that the savings in reduced absenteeism alone amounts to $130,600 annually. Supervision can readily attest to the increased productivity and work quality noted. Repetitious, needless, on-the-job direction and counseling by supervision was eliminated in this group.

The reception in the community has been enthusiastic. Other plants have asked for guidance in establishing similar programs. Seminars by our personnel have been held at hospitals, health departments, labor union conclaves, and at university conferences at their request. Local police courts frequently refer employees to the program because of misdemeanors occasioned by alcohol and

sentencing is suspended while the employee is "probated" to our group.

Enthusiasm is equally evident in the plant, from supervision and from program participants. Many participants feel they would not be living had not this program been strongly presented to them. Almost all feel they have found a new way of life and are financially sound for the first time. Families daily give expression of gratitude to program workers for rescuing them from family plights. Supervision feels a great load is lifted from problems incident to alcoholism; i.e. poor workmanship, absenteeism, tardiness, garnishees, scrapped parts, etc. Management recognizes that the program pays for itself in many ways.

Generic and Trade Name of Drug
Disulfiram — Antabuse (Ayerst)

Let's Take Another Look at Alcoholism

Lewis K. Reed, M.D.

THERE IS NOTHING NEW or very interesting in the problem of alcoholism. Neither is there anything new to report regarding the increase in the frequency of its occurrence and the disaster of its results. As in cancer, the failure of early diagnosis, acceptance, and treatment is the reason for the relatively poor showing that the medical profession as such is making in the "treatment-cure statistics." Alcoholism is more often missed, ignored, or mistreated than any other prevalent, serious disease.

Alcoholism, the word itself, has come to be used and defined with such variable connotation that it must be applied with discretion and usually some elaboration and explanation by the user, particularly when describing another person. The custom of alcohol usage is as old as mankind, and somehow the ability to "hold your liquor" has been linked with manhood or virility, stamina, guts, or will power and propriety. This is so true that clergymen, doctors in all of the healing arts, lawyers, sociologists, and other educated leaders who deal with people have a sort of undercurrent of disrespect for the alcohol addict. The physician's role is very important, because frequently he is the first one consulted. In his usual patient, he is accustomed to getting the unvarnished truth when he asks about symptoms and particularly if it is pain. However, every doctor learns to examine closely and to question the facts, when dealing with problems that involve litigation or compensated disability. The doctor, unless he is sophisticated on this point, will overlook the problem of alcoholism frequently because alcoholics are notably the most skillful liars of any single group of individuals. The reason for this is that the patient himself usually is living a lie, deluding himself with the idea that his troubles cannot possibly stem from his drinking, simply because he can't think for an instant about giving it up.

What is alcoholism? This is a disease in which the patient needs alcohol in some form on signal, and as a result of his taking the very first drink, he gets some very important facet in his life's program upset. To elaborate further, "on signal" means anything from a thirst that comes every hour to the need of periodically getting drunk in order to celebrate, or commiserate, or just to temporarily shut out unpleasant sounds and facts of life that have become unbearable. For many, the signal is cocktail hour daily at 4 PM or just the rising tide of a temper, a headache, or any other handy excuse that becomes habitual. It is essential in treating the alcoholic that the doctor is aware of the depth of the problem and that he can, in a discreet but firm way, gradually get the idea across to the patient that he must live without alcohol in his life. This is where Alcoholics Anonymous (A.A.) can help. A. A. is a nonprofit organization formed about 35 years ago by a stockbroker and a physician who wanted to get well.

Submitted February 9, 1970.

It works like a very well organized group therapy program in which some sound philosophic principles are the basis of developing a satisfactory habit and living pattern for each individual who becomes involved in the group activities (or therapy if you will). The adherents to the A.A. program probably number nearly a million and are distributed worldwide. Thus, persons wishing help can find a contact almost anywhere by simply looking in the phone book or contacting local police, clergy, or similar agencies. There are, of course, no certifying or qualifying boards within A.A. so that, like people generally, members of A.A. have varying talents and personalities. Like the first contact with a physician, it is a matter of good luck if the alcoholic's first contact is ideal. By and large, however, the example and suggestions that a sober alcoholic can give to a fellow victim are the first effective measures in helping the alcoholic in his recovery. One of the great benefits is the time factor. The alcoholic can find someone throughout the 24 hours to listen and talk with him when he is wrestling with the problem of how to avoid that next drink.

The usual difficulty in the doctor-patient relationship in alcoholism is that the patient drinks too much in order to have periods of escape from reality or boredom. The doctor often fails to recognize this in an individual who apparently is functioning at his vocation and with his family and avocations, at least on superficial view. The patient drinks to have these periods of escape and for the most part he finds them to be pleasant. Often, he is reaching the point of trouble when he first comes to the doctor, but he will lie invariably or will simply omit the truth with regard to his alcohol consumption. Usually he is actually kidding himself and hopes that the doctor will find some other explanation for his "nervousness," because he certainly doesn't want to be told he must stop drinking. He is making excuses of personal illness, family disturbances, discrimination, or some untruthful explanation for his absence from work and his reduced efficiency. He is trying to convince others as well as himself that there is some reason other than alcohol. The falsification and change in behavior pattern disturb the family so that ultimately there is deep trouble with the spouse, then with the children and other relatives, and finally with persons and activities outside.

Tranquilizers actually are not the answer in the treatment of the alcoholic. The doctor, of course, is obliged to look and to try to find something to do at once, but especially he must do something positive. The chiropractor manipulates the patient's neck and back and uses mechanical equipment to distract him during the time of the visit. The osteopath may use similar technics plus the addition of medication (usually a tranquilizer) and distracting clinical studies. The physician is likely to do the same things in general with writing of prescriptions and then killing time by sending the patient through a parade of consultants, then X-rays and laboratory studies to keep the patient busy and to occupy time. Obviously, adequate studies must be made to eliminate other organic and psychiatric disease before the competent physician can safely relegate his patient to specific treatment of the alcoholism. The busy doctor certainly does not have time to sit and ferret out the type of psychiatric analysis or counseling that is required to put the picture before the patient so that he himself can accept the diagnosis and proceed on a proper course. The average doctor does not have time to play detective and run an investigation to round up telltale signs of chronic or periodic drunkenness. Too often the doctor innocently gives the wrong medication when he prescribes a tranquilizer as he may be merely replacing one form of distraction with another. Alcoholic patients won't hesitate to take a larger dose of a tranquilizer than the prescription calls for without any fear or concern. So he finds that three or four tranquilizer capsules at one time may give a similar "buzz" to that which he gets from a couple of martinis. Many an alcoholic has put off coming to grips with his problem for a seriously long time on this account. He may quit drinking, but he substitutes tranquilizers, and he may kill himself in his car or by falling down the back stairs at home, just as he might have done with alcohol. Doctors don't realize that a patient who is otherwise perfectly honorable and reputable in every way may become as good a liar and thief as a narcotic addict when faced with his own alcoholic problem. The doctor does not have time to do what may be done by other understanding people.

Alcoholics Anonymous is, to be sure, a heterogenous collection of people, not systematically screened for membership, but in the main dedicated to the simple purpose of keeping one another sober in any way possible. Laymen in A.A. may become very experienced and talented as counsellors as they learn some of the tricks of emotional catharsis and suggestion, which the individual actually needs. Obviously a psychiatrist could accomplish the same and perhaps more, but most people cannot afford the cost or time of psychiatric care. Further, there are not nearly enough psychiatrists to go around. In A.A., there is a mixture of empathy, compassion mixed with discipline, understanding, instruction, and suggestion, which all combine to assist the individual in reaching his so-called "bottom." Bottom is sometimes referred to as "getting sick and tired of being sick and tired." Bottom is the point at which the individual is reaching out or crying out for help, and too often this is overlooked by others near him. Relatively few alcoholics reach skid row,

but literally millions have very disrupted lives that could be straightened out with the omission of alcohol and tranquilizers and the attained ability to face reality throughout the entire day. In A.A., he learns the way to get through the unbearable minute or few minutes in which he so often has felt that he could not endure the misery of his emotions. He learns to live "a day at a time." A great deal of this is simply the development of a pattern of action on his part by which he gets into motion and makes some positive step to avoid taking a drink or a pill. This may consist simply of dialing a telephone number and talking with his sponsor or an understanding person or getting out of where he is to do something for himself. This may consist of going to visit another alcoholic or to a halfway house or alcoholic clinic, where he himself may become a therapist rather than to sit in one place and wallow in his own self-pity. The alcoholic is inclined to justify each drunk that he starts, and the sooner he learns that he doesn't dare take the first drink, the sooner he can recover. A.A. offers a multi-discipline approach in which a spiritual or religious emphasis, an occupational-therapeutic, or a "twelfth step approach" is made by the individual to distract himself when drinking seems imminent. There are seldom two alcoholics in A.A. who follow the identical pattern of self-discipline, once they attain sobriety. On how deep were the drinking pattern and deterioration depends the length of time before the individual can think clearly and maintain his own discipline without considerable help. It is learning that his alcoholism is not something peculiar to himself and that there are others who have succeeded and can help him in attaining sobriety that produce the desired result. By sharing with others his own self-respect and hope, he is able to strengthen the endurance of his own sobriety.

Alcoholism as a term or a diagnosis carries such a connotation and stigma with many people that a cold-blooded original approach to the problem with this diagnosis is impossible if any success is expected. If a doctor frankly tells his patient that he is an alcoholic, he may lose his patient and even the family, depending upon the preconditioning and the patient's interpretation of this word. Call it whatever you will, the doctor should recognize that the use of alcohol or even the tranquilizing drugs is a form of addiction of only a slightly lesser degree than actual narcotic addiction. His approach then must be along similar lines. The essential ingredient to success is a desire on the part of the individual to survive. Until he himself can realize what is wrong and what has to be done, combined with his wish to remain alive, he doesn't stand much chance of getting any better. The knowledgeable doctor can help.

Doctors in all the healing arts, clergymen, lawyers, and social counsellors would find useful and helpful experience in learning about available local facilities for help from Alcoholics Anonymous. In most communities, there are frequent A.A. meetings where genuinely interested persons are welcome as observers or participants. The local telephone book may list Alcoholics Anonymous, through which contacts and arrangements may be made at a local level. More detailed information can be obtained by addressing inquiries to: General Service Office — Alcoholics Anonymous, P.O. Box 459, Grand Central Station, New York, N. Y., 10017.

For physicians interested in further knowledge of alcoholism, applications may be made to: American Medical Society on Alcoholism, Inc., 150 East 52nd St., New York, N. Y., 10022.

Physicians who are members of A.A. or have self-interest in the problem may inquire to: Secretary, International Doctors in Alcoholics Anonymous, 1950 Volney Road, Youngstown, Ohio, 44511.

THE DRUNK IN COURT. — A total of 151 men charged with drunkenness with or without aggravations were interviewed immediately after their appearance before the magistrates. The survey was conducted in two Metropolitan courts: one in an area frequented by vagrants, and the other in a mixed middle-class and working-class area.

Few of the offenders were casual roisterers and the majority had a serious drinking problem. Half the offenders showed evidence of chemical dependence on alcohol as determined by morning shakes, morning relief drinking, amnesias, inability to stop drinking, and hallucinatory experiences.

The majority of the offenders were suffering from gross social isolation.

Existing ways of dealing with such men seem inadequate. A rehabilitation service is needed, with hostel accommodation, and particular attention should be paid to first offenders. — Denis Gath, B.M., M.R.C.P., D.P.M., et al, London: *British Medical Journal,* 4:801-811, December 28, 1968.

Tetralogy of Fallot

James R. Malm, M.D.*

TETRALOGY OF FALLOT is a totally correctible cardiac anomaly, accounting for 30 percent of all infants with cyanotic heart disease and previously associated with a 25 percent mortality in the first year of life. While the original anatomic description of this defect included dextroposition of the aorta and right ventricular hypertrophy, these are secondary to the basic abnormalities, namely, a large ventricular septal defect and severe outflow tract obstruction from the right ventricle. The hemodynamic result is shunting of systemic venous blood across the septal defect to the left ventricle resulting in peripheral cyanosis and reduced pulmonary blood flow. The degree of outflow obstruction is dynamic, varying with the infant's level of activity or excitement; thus the level of cyanosis may, from moment to moment, change markedly.

The recognition of cyanosis in an infant is an indication for complete diagnostic studies including cardiac catheterization and angiography. Catheterization at this age is safe and establishes an anatomic diagnosis, providing clear guidelines for future management. Life-threatening syncopal episodes, secondary to cerebral hypoxia, or other signs of severe reduction in pulmonary blood flow are an indication for a palliative systemic to pulmonary artery shunt. The recent use of the right pulmonary artery to ascending aorta anastomosis has provided excellent increased pulmonary blood flow, although it is associated with a significant mortality in infants below 6 months of age. Cyanosis, exertional dyspnea, and squatting may not appear until the child's demands for oxygen increase with the onset of walking. A shunting procedure is recommended for symptomatic toddlers and children under 4 years of age to relieve symptoms, allowing normal growth and development until an age is reached when total correction can be carried out with a low mortality. We recommend carrying out total correction on any symptomatic child over the age of 4 years, irrespective of the presence or absence of the previous shunting operation. Elective total correction of the anomaly is indicated in the relatively asymptomatic child between the ages of 7 and 10 years. The effectiveness of the palliative shunts decreases in 60 percent of patients as the oxygen demands increase with age, and 7 percent develop endocarditis at the site of the surgically created ductus. All patients with functioning shunts should be reevaluated for total correction prior to age 15 years.

Total correction of this anomaly requires closure of the ventricular septal defect, relief of the outflow tract obstruction of the right ventricle, and ligation of any existing, previously constructed shunt. The correction can be carried out with a mortality of less than 10 percent, and the postoperative course is directly affected by the completeness of the surgical repair. When a complete repair has been carried out the postoperative course is benign, without evidence of cardiac failure or

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Provided by the American Heart Association, Inc. and made available to *The Journal* by the Ohio State Heart Association.

pulmonary complications. Complete correction is sometimes limited by the presence of multiple small septal defects or an extreme degree of narrowing, even hypoplasia, of the outflow tract of the right ventricle. When the outflow tract is markedly narrowed, an outflow tract patch or gusset is required to increase the size of the pulmonary annulus. This patch results in pulmonary valvular insufficiency and is usually associated with moderate to severe degrees of right heart failure during the first two to three weeks postoperatively. These patients require digitalization for two to three months, but they have manifested no cardiac limitations in long-term follow-up. An extreme form of the anomaly may exist with complete absence of the pulmonary artery. This type of defect can now be repaired utlizing a preserved human aortic homograft as a conduit between the right ventricular outflow tract and main pulmonary artery. This provides a graft with aortic valves functioning at the pulmonary valve level, avoiding a marked degree of pulmonary valvular insufficiency. These grafts have improved the immediate postoperative management of these patients.

The late postoperative results have been dramatic. Corrected patients have normal exercise tolerance and no evidence of cyanosis. In our own series, postoperative catheterization data suggest that over 90 percent of the patients have normal or near-normal postoperative hemodynamics. In addition, late hemodynamic studies with exercise demonstrate that these patients have a normal response in cardiac output to exercise. We feel that these postoperative studies and the maintenance of excellent hemodynamics in a follow-up period suggest that long-term outlook is excellent for these patients.

THE SECRET OF NATURE.—In inquiries respecting the laws of the world and the frame of things, the highest reason is always the truest. That which seems faintly possible — it is so refined, is often faint and dim because it is deepest seated in the mind among the eternal verities. Empirical science is apt to cloud the sight, and by the very knowledge of functions and processes, to bereave the student of the manly contemplation of the whole. The savant becomes unpoetic. But the best read naturalist who lends an entire and devout attention to truth, will see that there remains much to learn of his relation to the world, and that it is not to be learned by any addition or subtraction or other comparison of known quantities, but is arrived at by untaught sallies of the spirit, by a continual self-recovery, and by entire humility. He will perceive that there are far more excellent qualities in the student than preciseness and infallibility; that a guess is often more fruitful than an indisputable affirmation, and that a dream may let us deeper into the secret of nature than a hundred concerted experiments. — Ralph Waldo Emerson, *Nature.*



PROTEIN CONTENT / 7 oz. Serving*

Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
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Only Flagyl has been able to achieve rates of cure consistently above 90 per cent and often up to 100 per cent in trichomonal infections in both men and women.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

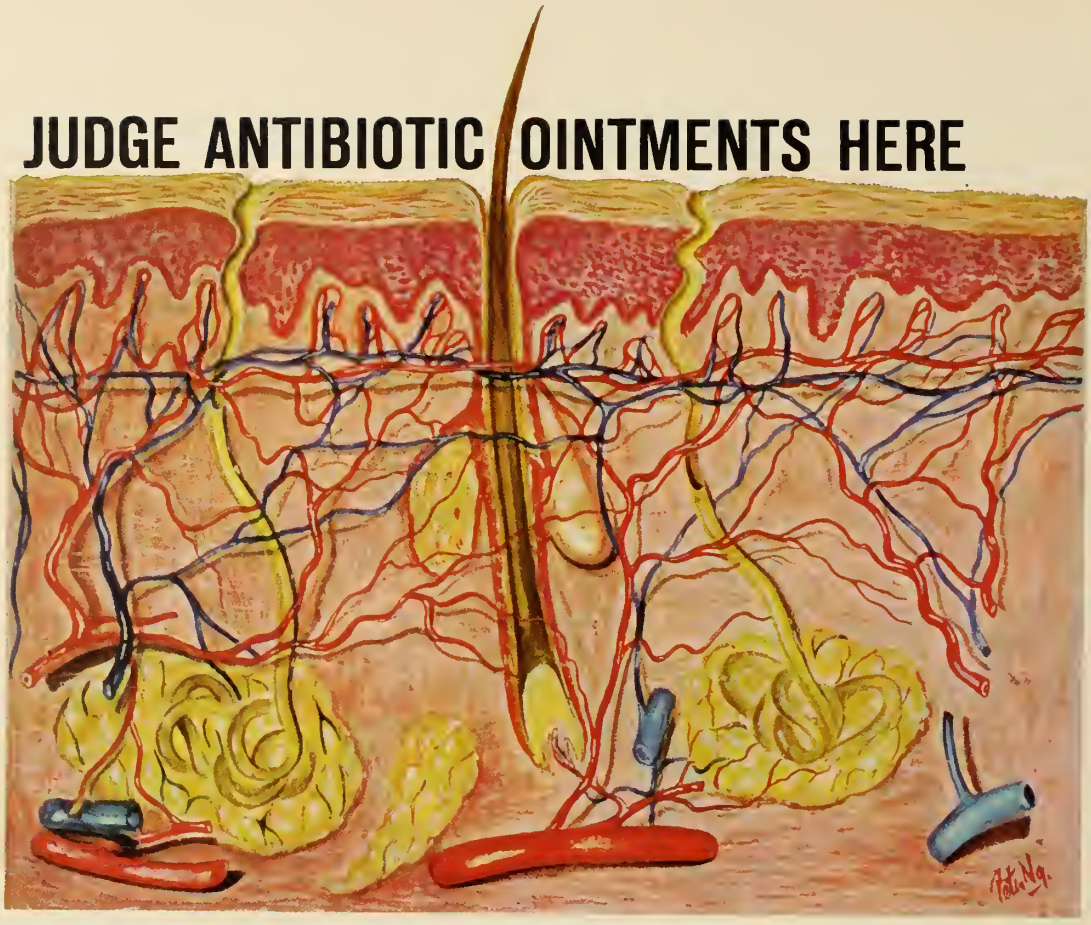
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*References available on request.

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

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Professional Activities

Hill-Burton Building Fund Allotment for Ohio Is Announced

The State of Ohio is to receive $7,684,355 for the construction and modernization of hospitals and related health facilities to be administrated in fiscal year 1971 (beginning July 1, 1970) under the Hill-Burton program, it was announced by Dr. Emmett W. Arnold, director of the Ohio Department of Health. This represents a reduction of $4,798,360 from the amount received in the last fiscal year.

Of the allotment $2.5 million plus is allocated for general hospitals and related facilities including local health departments, $929 thousand plus for modernization of obsolete facilities, $2.9 million plus for extended care and skilled nursing home facilities, $828 thousand plus for diagnostic and treatment centers, and $414 thousand plus for rehabilitation centers.

Ohio ranks fifth in the amount of funds received among the states and territories in the United States.

A new library facility in Cincinnati General Hospital has been named the Robert A. Lyon Pediatric Library in honor of Dr. Lyon, professor of pediatrics at the University of Cincinnati College of Medicine. Dr. Lyon will retire from active teaching duties on September 1, 1970, and will assume the title professor emeritus.

Deadline for Practical Nurse Waiver Examination Announced

All Ohio applicants for practical nurse licensure by waiver are advised of the following provisions as announced by Dorothy B. Leupp, R.N., Executive Secretary of the Board of Nursing Education and Nurse Registration, 21 W. Broad Street, Columbus 43215:

December 31, 1970 is the **deadline** for submitting applications for the practical nurse waiver examination. Any applications dated later than **midnight December 31, 1970 will not be accepted** by the Ohio State Board of Nursing Education and Nurse Registration.

Prohibition of Practice and Penalty for Violation: According to Section 4723.16 of the Revised Code of Ohio, no person or practical nurse shall practice nursing as a licensed practical nurse in this State after April 1, 1971 without first obtaining an Ohio license. Whoever violates this section shall be fined not less than one hundred nor more than five hundred dollars or imprisoned not more than ninety days or both according to Section 4723.99 of the Revised Code.

Ohioan Named to AMA Board of Trustees in Action at Chicago Convention

FOR OHIO DOCTORS, highlight of the 1970 American Medical Association 1970 convention in Chicago June 21-25 was the election of John H. Budd, M.D., Cleveland, to the Board of Trustees of the AMA.

A family physician in private practice, Dr. Budd has been a member of the Ohio State Medical Association delegation to the AMA since 1960 and chairman of the delegation since 1962. The AMA House of Delegates elected him to the 12-man board, which is responsible for conducting AMA affairs between sessions of the House.



Dr. Budd

A veteran member of the OSMA House of Delegates and a past president of the Academy of Medicine of Cleveland and Cuyhoga County, Dr. Budd has served on and has chaired many medical committees on the local, state, and AMA level.

While news media reports gave headlines to a small, purely antagonistic group of demonstrators that were given a courteous hearing before a special House committee, delegates considered and passed on a record 201 items.

Ohio Delegates Effective

The Ohio delegation carried five resolutions to the meeting, and gained favorable action on four of the five.

An OSMA resolution calling for approval of the report of the Committee on Long Range Planning and Development was adopted. The House established a permanent Council on Long Range Planning and Development to study and make recommendations regarding long range objectives of the AMA.

An OSMA resolution calling for AMA to develop accurate statistics for use against false and misleadiing statistics "used for discrediting the medical care in this country" was adopted.

An OSMA resolution called for the AMA to oppose arbitrary removal of drugs from the market by FDA, and also called for more private practitioners on future drug efficacy panels used by FDA. The resolution was adopted.

Also adopted by a standing moment of silent tribute was an OSMA resolution memorializing the late George A. Woodhouse, M.D., former chairman of the Ohio delegation, former chairman of the AMA Judicial Council and an OSMA Past President. Dr. Woodhouse died April 21.

An OSMA resolution asking AMA to develop a medical administration management course for retiring state association presidents was referred to the Board of Trustees for study.

Other actions of the House of Delegates of particular interest to Ohio physicians include:

$40 Dues Increase

★Effective January 1, 1971, a $40 dues increase, bringing annual AMA dues to $110. The Board of Trustees had requested an $80 increase.

★Recommendation to permit abortion when performed by a licensed physician in an accredited hospital after consultation with two other physicians chosen for their professional competence, with determination based on sound clinical judgment and informed patient consent.

★Approval of a plan to negotiate an AMA-state associations sponsored professional liability insurance program for AMA members.

★Definition of health as a state of physical and mental well-being.

★Action calling for more physician participation in the development and guidance of non-medical aspects of health services.

★Action calling for development of methods of eliminating medical manpower shortages, bearing in mind the present maldistribution of physicians.

Other Actions

In other actions the House of Delegates:

★Approved physician assistant programs, but opposed licensing such assistants.

★Urged state associations to establish departments of economic research. (OSMA has such a department.)

★Reiterated usual, customary and reasonable fee concept in encouraging states to deal energetically with third parties.

★Endorsed life-long postgraduate study for all physicians, on a voluntary basis.

★Endorsed termination of an internship independent of residency, and urged unification of internship-residency years into "a coordinated whole."

★Instructed investigation of feasibility of bringing allied health professions into a collaborative class of AMA membership.

AMA to meet in Cincinnati

★Selected Cincinnati as site for 1972 Clinical Convention.

★Called for legislation controlling manufacture and distribution of amphetamines and barbiturates, and asked for closer surveillance of proprietary drug advertisements.

★Went on record as firmly opposing repeal or modification of drug anti-substitution laws and regulations.

★Resolved that Joint Commission on Accreditation of Hospitals accept on hospital charts terms "negative," "within normal limits," and "normal," and reaffirmed position that general practitioners should enjoy hospital privileges commensurate with their training and demonstrated abilities.

★Approved a "communications program for the 1970's," including television documentaries, educational advertising, and other activities.

★Approved Judicial Council report stating it is not unethical for a physician to own or have interest in a for-profit hospital, but it is definitely unethical for such physician to send a patient to such hospital or prolong his stay for the financial benefit of the physician.

★Reiterated strong endorsement of necessity of adequate peer review programs.

Warns of Chiropractic

★Called on state associations to inform legislators about "the health hazards posed by the cult of chiropractic."

AMA trustee Wesley W. Hall, M.D., Reno, Nevada, was elected president-elect. Walter C. Bornemeier, M.D., Chicago, was installed as president.

A former OSMA president and a member of the Ohio Delegation, George W. Petznick, M.D., Cleveland, was reelected to the Judicial Council.

Ohio delegates, in addition to Dr. Budd and Dr. Petznick, who participated in the proceedings, included Drs. P.B. Hardymon, Columbus; Harry K. Hines, Cincinnati; T. L. Light, Dayton, Carl A. Lincke, Carrollton, Frederick P. Osgood, Toledo, OSMA President-elect P. John Robechek, Cleveland, and Robert E. Tschantz, Canton.

Alternates attending were OSMA immediate Past President Robert N. Smith, Toledo, who was temporarily seated as a delegate to nominate Dr. Budd, Drs. Oscar W. Clarke, Gallipolis, Henry A. Crawford, Cleveland; W. J. Lewis, Jr., Dayton; Frank H. Mayfield, Cincinnati, Lawrence C. Meredith, Oberlin, and Jack Schreiber, Canfield.

Also active in the meeting were OSMA President Richard L. Fulton, M.D., Columbus, and Fourth District Councilor George N. Bates, M.D., Toledo.

Two Ohio Physicians Honored by ACP

Two specialists in internal medicine in Ohio have been honored by the American College of Physicians for their prominence in the contributions to internal medicine.

They are Charles A. Doan, M.D., Columbus and A. Carlton Ernstene, M.D., Cleveland. Both were elected as Masters, the highest membership category in the international medical specialty society.

Charles H. Rammelkamp, Jr., M.D., Cleveland, ACP Governor for Ohio, said the Masterships signify Fellows of the College who have attained an eminence in science or in medical research, or in the practice or teaching of medicine.

U. S. Institute Requests Referral of Certain Patients

The cooperation of physicians is requested in the referral of patients with acute intermittent porphyria for a study being conducted by the Metabolism Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health.

Patients who have no other complicating diseases are preferred and will be admitted as inpatients for study and treatment. Upon discharge, the referring physician will receive a summary of the findings and treatment which has been instituted.

Physicians interested in having their patients considered for admission to this study may write or telephone: Joseph R. Bloomer, M.D., Clinical Center, Room 4-N-117, National Institutes of Health, Bethesda, Maryland 20014; Telephone: 301-496-5955.

Symposium on the Pancreas

AMONG OUTSTANDING continuing education programs for the fall is one entitled "Ohio State University College of Medicine Centennial Symposium on the Pancreas," to be held on the campus October 6 and 7. Cosponsor is the Central Ohio Diabetes Association.

The two-day symposium will present recent advances in exocrine and endocrine diseases of the pancreas. Sixteen outstanding authorities from other universities will join the OSU faculty for this program.

The first day will feature discussions on the physiologic regulation of pancreatic secretion, diagnosis, management, and complications of acute and chronic pancreatitis, ulcerogenic tumor of the pancreas, pancreatic cholera syndrome, and cystic fibrosis.

The second day will be concerned with diabetes mellitus and the subjects covered will include pharmacologic control of gluconeogenesis, pathogenesis of diabetes mellitus, diabetes and pregnancy, and management of juvenile diabetes.

Additional information may be obtained from the Center for Continuing Medical Education, Ohio State University College of Medicine, 320 W. Tenth Avenue, Columbus, 43210.

Guest Faculty

Marion C. Anderson, M.D., professor and chairman, Department of Surgery, Medical College of Ohio at Toledo.

Rubin Bressler, M.D., professor of medicine and pharmacology, Duke University Medical Center Durham, N. C.

Stefan S. Fajans, M.D., professor of internal medicine, University of Michigan School of Medicine, Ann Arbor.

Norbert Freinkel, M.D., professor of medicine, Northwestern University School of Medicine, Chicago.

James D. Jamieson, M.D., assistant professor, The Rockefeller University, New York.

Henry D. Janowitz, M.D., professor of medicine, Mt. Sinai Medical School, director, Division of Gastroenterology Mt. Sinai Hospital, New York.

Harvey C. Knowles, Jr., M.D., professor of medicine, University of Cincinnati College of Medicine.

Rachmiel Levine, M.D., professor and chairman, Department of Medicine, New York Medical College, New York.

Paul E. Lacey, M.D., professor and chairman, Department of Pathology, Washington University School of Medicine, St. Louis.

T. M. Lin, Ph.D., Lilly Research Laboratories, Eli Lilly and Company, Indianapolis.

James E. McGuigan, M.D., professor of medicine, director, Division of Gastroenterology University of Florida, Gainesville, Florida.

Tetsuo Maki, M.D., professor and chairman, Department of Surgery, Tohoku University School of Medicine, Sendai, Japan.

Maurice Mercardier, M.D., Professor Agrege A La Faculte, American Hospital of Paris.

George L. Nardi, M.D., consulting surgeon, Massachusetts General Hospital, Boston.

Donald F. Steiner, M.D., professor of biochemistry, University of Chicago Pritzker School of Medicine.

Roger H. Unger, M.D., professor of medicine, University of Texas, Southwestern Medical School, Dallas.

OSU Faculty

Norton J. Greenberger, M.D., associate professor of medicine, director, Division of Gastroenterology.

Gordon A. Young, M.D., assistant professor of pediatrics.

John E. Jesseph, M.D., professor and vice-chairman, Department of Surgery.

Robert M. Zollinger, M.D., professor and chairman, Department of Surgery.

Thomas G. Skillman, M.D., professor of medicine, director, Division of Endocrinology.

Richard L. Fulton, M.D., associate clinical professor of medicine; President of the Ohio State Medical Association.

The program has been announced as follows:

Wednesday Morning, Oct. 6

Registration (8:00 - 8:30 a.m.)

Welcome — Richard L. Meiling, M.D., Dean, OSU College of Medicine

Anatomy and Physiology of the Pancreas
Moderator: Dr. Greenberger

Anatomy of the Pancreas and Secretion of Pancreatic Enzymes — Dr. Jamieson

Gastrin: Structure-Function Relationships — Dr. McGuigan

(Continued on Next Page)

Secretin, Cholecystokinin-Pancreozymin, and Glucagon: Structure-Function Relationships — Dr. Lin

Physiologic Regulation of Pancreatic Exocrine Secretion — Dr. Janowitz

Pathogenesis of Acute Pancreatitis — Dr. Anderson

Question Period

Wednesday Afternoon

Acute and Chronic Pancreatitis
Moderator: Dr. Zollinger

Diagnosis, Management, and Complications of Acute Pancreatitis — Dr. Nardi

Diagnosis and Medical Management of Chronic Pancreatitis — Dr. Greenberger

Pseudocysts of the Pancreas — Dr. Mercardier

Surgical Management of Chronic Pancreatitis — Dr. Maki

Ulcerogenic Tumor of the Pancreas and Pancreatic Cholera Syndrome — Dr. Zollinger

Carcinoma of the Pancreas — Dr. Jesseph

Diagnosis and Management of Cystic Fibrosis — Dr. Young

Thursday Morning, Oct. 7

Diabetes Mellitus
Moderator: Dr. Skillman

Electron Microscopy of the Endocrine Pancreas — Dr. Lacey

Proinsulin and Big Insulins — Dr. Steiner

Pharmacologic Control of Gluconeogenesis — Dr. Bressler

Abnormal Alpha Cell Function: A Characteristic of Genetic Diabetes Mellitus — Dr. Unger

Pathogenesis of Diabetes Mellitus — Dr. Fajans

Question Period

Thursday Afternoon

Moderator: Dr. Fulton

Current Concepts and Controversies in the Management of Diabetes Mellitus — Dr. Levine

Problems in the Management of Juvenile Diabetes — Dr. Knowles

Diabetes and Pregnancy —

Complications of Diabetes Mellitus — Dr. Skillman

Question Period

A Day of Cardiology Scheduled at OSU

"A Day of Cardiology" will be presented by the Department of Internal Medicine, Ohio State University College of Medicine, on Friday, October 16. The program begins at 9:00 a.m. and runs to 4:45 p.m.

Persons interested in additional information are invited to contact Arnold M. Weissler, M.D., Department of Medicine, 410 West 10th Avenue, Columbus 43210.

The program has been announced as follows:

Acute Myocardial Infarction
Dr. Arnold M. Weissler and panel

Treatment of Angina Pectoris
Dr. Richard P. Lewis and panel

Heart Block
Dr. Charles F. Wooley and panel

Hypertension
Dr. Thomas F. Ferris and panel

Ohio Physician's Water Color Reproduced as Cover Art

"Pink Sand," a water color painted by Samuel W. Robinson, M.D., of Columbus, was reproduced in color on the July cover of *Minnesota Medicine*, official publication of the Minnesota State Medical Association.

The scene was painted in 1968 at Harbour Island, Bahamas, on the Atlantic Beach side of Harbour Island. Harbour Island is just off the northern tip of Elenthera. The pink sand is seen at water's edge along Elenthera but particularly on Harbour Island and is more impressively pink after being washed by each wave. On this beach coral has added some faint color flecks to the sand which gives the beach a bit of a pink glow.

"Pink Sand" won first prize in water color in 1968 at the exhibition of the American Physicians Art Association, which show is held in conjunction with the American Medical Association convention.

The Southwestern Ohio Society of Family Physicians presented a gift of $1,000 to the University of Cincinnati College of Medicine. Dr. Elmer Schlueter, president of the SOSFP, presented the gift to Dr. Clifford G. Grulee Jr., dean of the medical college, during annual Medical Alumna Association banquet.

OSMA Family Practice Scholarships . . .

Two Medical Students Entering School This Fall And Six Now in School Are Aided by OSMA Backing

THE AWARDING of medical scholarships of $2,000 each, to John E. Pappas, Cuyahoga Falls, Ohio, and John H. Surry, Youngstown, Ohio, was announced by OSMA's Family Practice Scholarship Subcommittee.

Dr. Richard L. Fulton, Columbus, OSMA President, in announcing the selections to the public press, said this year marked the 22nd annual awarding of the scholarships.



John E. Pappas

Mr. Pappas, 21, completed his premedical studies at the University of Akron, and will enter the Temple University School of Medicine, Philadelphia, Pennsylvania, this fall.

Mr. Surry, 21, will enter the St. Louis University School of Medicine this fall, having completed his premedical studies at John Carroll University, Cleveland.

The two winning applicants were selected in competition judged on the basis of character, integrity, intelligence, mature personality, interest in community life, need, leadership, and scholastic ability.

Messrs. Pappas and Surry will receive $500 for each year of their medical studies. Dr. Fulton stated that this fall there will be eight students in medical school who have received the OSMA scholarships. Included are William H. Kose of Pickerington, a senior in the Ohio State University College of Medicine; Alan T. Tong of McComb, also a senior at OSU; Mrs. Rebecca (Terrell) Strafford of New Vienna and Larry R. Thomas of Findlay, both OSU juniors; Paul R. Garrett of East Palestine, a sophomore at the Medical College of Ohio at Toledo, and Richard W. Pine of Columbiana, a sophomore at Case Western Reserve School of Medicine.



John H. Surry

Dr. Fulton pointed out that the scholarships are a part of the Association's continuous activities to stimulate young men and women of Ohio in becoming Doctors of Medicine, with emphasis on their becoming family physicians.

"Clinical Pathology Series" is the title of a group of education films available on loan from the U. S. Public Health Service. Numerous other films are available. Details may be obtained by writing: National Medical Audiovisual Center (Annex), Station K, Atlanta, Georgia 30324.

Robert A. Lang, executive secretary of the Academy of Medicine of Cleveland, has been named a member of the Board of Trustees of the Cleveland Better Business Bureau.

Ohio Specialty Organizations

FOLLOWING IS A ROSTER of Ohio Specialty Societies, with the names and addresses of presidents, secretaries, and in some instances program chairmen, brought to the attention of *The Journal* before this issue went to press. Some of these organizations meet and present programs during the OSMA Annual Meeting. Others hold programs at other times of the year. Every effort has been made to bring this roster up to date for the 1970-1971 season. The editorial staff will be glad to supplement this information at any time.

Ohio Chapter, American College of Chest Physicians — President: Herman W. Reas, M.D., Dept. of Pediatrics, Medical College of Ohio at Toledo, P.O. Box 6190, Toledo 43614; Secretary-Treasurer: Richard A. Krumholz, M.D., Director, Institute of Respiratory Diseases, Kettering Medical Center, Dayton 45429.

Ohio Ear, Nose and Throat Society — President: Willard Parker, M.D., Cleveland Clinic, 2020 East 93rd Street, Cleveland 44106 (Also Chairman, Section on Ear, Nose and Throat); Secretary: Donald A. Shumrick, M.D., University of Cincinnati Medical Center, 3231 Burnet Avenue, Cincinnati 45229 (Also Secretary, Section on Ear, Nose and Throat).

Ohio Society of Internal Medicine — President: Edward O. Hahn, M.D., Westgate Medical Arts Center, Fairview Park 44126; Secretary-Treasurer: Robert W. Jones, M.D., 120 Sturges Avenue, Mansfield 44903 (Also Chairman, Section on Internal Medicine).

Ohio Neurosurgical Society — President: J. Hugh Webb, M.D., 3939 Monroe Street, Toledo 43606 (Also Chairman, Section on Neurological Surgery); Secretary: James E. Barnes, M.D., 1275 Olentangy River Road, Columbus 43212 (Also Secretary, Section on Neurological Surgery).

Ohio Ophthalmological Society — President: Robert E. Traul, M.D., 1909 S. Main Street, Findlay 45840; Secretary: Robert H. Magnuson, M.D., 150 East Broad Street, Columbus 43215.

Ohio Orthopaedic Society — President: Russell P. Rizzo, M.D., 13535 Detroit Avenue, Lakewood 44107 (Also Chairman, Section on Orthopaedic Surgery); Secretary: John B. Roberts, M.D., University Hospital, 410 W. 10th Avenue, Rm. N-847, Columbus 43210 (Also Secretary, Section on Orthopaedic Surgery).

Ohio Society of Pathologists — President: William Collins, M.D., Lima Memorial Hospital, Lima 45804 (Also Chairman, Section on Pathology); Secretary: Robert Thomas, M.D., Dept. of Laboratories, Elyria Memorial Hospital, Elyria 44035 (Also Secretary, Section on Pathology).

Ohio Chapter, American Academy of Pediatrics — President Charles Q. McClelland, M.D., 20629 North Park Boulevard, Cleveland 44118 (Also Chairman, Section on Pediatrics); Secretary: George A. Smith, M.D., 908 N. Fountain Avenue, Springfield 45504 (Also Secretary, Section on Pediatrics).

Ohio Society of Physical Medicine and Rehabilitation — (officers to be announced).

Ohio Psychiatric Association — President: Donald H. Burk, M.D., Harding Hospital, 445 East Granville Road, Worthington 43085 (Also Chairman, Section on Psychiatry and Neurology); Secretary: Robert J. McDevitt, M.D., 3333 Vine Street, Cincinnati 45220 (Also Secretary, Section on Psychiatry and Neurology); Executive Secretary: Mr. Gene P. King, 88 East Broad Street, Columbus 43215; Program Chairman: Gordon F. Ogram, M.D., State Dept. of Mental Hygiene, 1210 State Office Bldg., Columbus 43215 (Also Program Chairman, Section on Psychiatry and Neurology).

Ohio State Radiological Society — President: Robert D. Berkebile, M.D., Elyria Memorial Hospital, Elyria 44035; Secretary: Joseph H. Hanson, M.D., 1544 South Byrne Road, Toledo 43614; Program Chairman: Charles Klein, M.D., 3939 Monroe Street, Toledo 43606.

Ohio Committee on Trauma, American College of Surgeons — Chairman: Wesley Furste, M.D., 3545 Olentangy River Road, Columbus 43215; Secretary-Treasurer: Ray E. Ebert, M.D., 327 East State Street, Columbus 43215; Program Chairman: Thomas R. Kelly, M.D., 550 East Market Street, Akron 44308.

Ohio State Society of Thoracic Surgeons — President: Robert Taylor, M.D., 1170 Fidelity Medical Bldg., 211 S. Main Street, Dayton 45402; Secretary: H. Gene Ewy, M.D., 819 West Broad Street, Columbus 43212.

OSMA Specialty Sections

SPECIALTY SECTIONS aid the Committee on Scientific Work in planning programs for the OSMA Annual Meeting. Most of these Sections met during the 1970 Annual Meeting and elected or reelected officers. This roster brings up to date the names and addresses of the chairman, secretary, and in some instances program chairman of each section for the benefit of persons who may wish to discuss program plans. Readers are invited to notify *The Journal* of any changes of address or other data relating to the Sections.

Section on Anesthesiology — Chairman: John R. Anderson, M.D., University Hospital, Room 408, 410 West 10th Avenue, Columbus 43210; Secretary: Lincoln L. Moore, M.D., 2116 Northridge Drive, Westchester Park, Springfield 45504.

Section on Colon and Rectal Diseases — Chairman: Jerome Surdyk, M.D., 900 Fidelity Building, Dayton 45402; Secretary: Carlos O. Andarsio, M.D., 1834 E. High Street, Springfield 45505.

Section on Directors of Medical Education — Chairman: Robert V. Bachman, M.D., Polyclinic Hospital, 6606 Carnegie Avenue, Cleveland 44103; Secretary C. Hedrick, M.D., Kettering Memorial Hospital, 3535 Southern Boulevard, Kettering 45429; Program Chairman: Jerry I. Newman, M.D., Aultman Hospital, 625 Clarendon Avenue, S.W., Canton 44710.

Section on Ear, Nose and Throat — Chairman: Willard Parker, M.D., Cleveland Clinic, 2020 East 93rd Street, Cleveland 44106 (Also President, Ohio ENT Society); Secretary: Donald A. Shumrick, M.D., University of Cincinnati Medical Center, 3231 Burnet Avenue, Cincinnati 45229 (Also Secretary, Ohio ENT Society).

Section on General Practice of Medicine — Chairman: Richard C. Brandes, M.D., 2094 Tremont Center, Columbus 43221; Secretary: L. Eugene Plummer, M.D., 275 Scioto and Darby Creek, Hilliard 43026.

Section on Internal Medicine — Chairman: Robert W. Jones, M.D., 120 Sturges Avenue, Mansfield 44903; Secretary: Donald G. Pocock, M.D., 420 Lake Avenue, N.E., Massillon 44646 (Also Program Chairman).

Section on Neurology — Chairman: Tom Wallace, M.D., Cleveland Clinic, 2020 East 93rd Street, Cleveland 44106; Secretary: Norman Allen, M.D., University Hospitals, 410 West 10th Avenue, Columbus 43210; Program Chairman: W. C. Wiederholt, M.D., University Hospitals, 410 W. 10th Avenue, Columbus 43210.

Section on Neurological Surgery — Chairman: J. Hugh Webb, M.D., 3939 Monroe Street, Toledo 43606; Secretary: James E. Barnes, M.D., 1275 Olentangy River Road, Columbus 43212.

Section on Obstetrics and Gynecology — Chairman: Stephen Hornstein, M.D., 8040 Reading Road, Cincinnati 45237; Secretary: (to be announced).

Section on Occupational Medicine — Chairman: Edward F. Arscott, M.D., Ford Motor Company, P.O. Box 9900, Cleveland 44142; Secretary: Bruce Dickerson, M.D., T. R. W. Inc., 23555 Euclid Avenue, Cleveland 44117.

Section on Ophthalmology — Chairman: Jerry W. Draheim, M.D., 3939 Monroe Street, Toledo 43606; Secretary: S. Baird Pfahl, M.D., 740 E. Park Street, Sandusky 44870.

Section on Orthopaedic Surgery — Chairman: Russell P. Rizzo, M.D., 13535 Detroit Avenue, Lakewood 44107 (Also President, Ohio Orthopaedic Society); Secretary: John B. Roberts, M.D., University Hospital, 410 W. 10th Avenue, Rm. N-847, Columbus 43210 (Also Secretary, Ohio Orthopaedic Society); Program Cochairmen: Victor H. Frankel, M.D., 2065 Adelbert Road, Cleveland 44106; and Charles Evarts, M.D., Cleveland Clinic Hospital, 2020 East 93rd Street, Cleveland 44106.

Section on Pathology — Chairman: William Collins, M.D., Lima Memorial Hospital, Lima 45804 (Also President, Ohio Society of Pathologists); Secretary: Robert Thomas, M.D., Dept. of Laboratories, Elyria Memorial Hospital, Elyria 44035 (Also Secretary, Ohio Society of Pathologists); Program Chairman: H. B. Davidson, Jr., M.D., 267 East Broad Street, Columbus 43215.

(Continued on Page 837)

Sandoz announces...

a new agent for the alcohol-dependent patient who wants to quit

and

a program for the Ohio physician who wants to help





a major tranquilizer with specific advantages for the alcohol-dependent patie

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunctio or interfered with functional rec ery of impaired liver.
5. Four tablet strengths to allow flexib ity of dosage (usual starting dos for the problem drinker, 10 mg. t.i.c for the frank alcoholic, 25 mg. b.i.c
6. Injectable form available for acu episodes.



rogram for early recognition and successful treatment:

Alcoholism in Ohio*

State Rank

tal no. alcaholics	5th
p. per capita	13th
er capita consumptiant	30th

Ohio Physicians' Report
(compared with U.S. average)

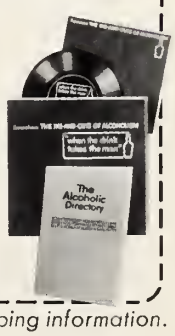
	%Ohio	%U.S.
e 5 ar mare prablem inkers in 2-month periad	33.8	37.1
alf or mare seen are wamen	38.0	37.4
eat, rather than refer	73.7	72.6
are cammunity services eeded	64.0	63.0

*ased on preliminary data supplied by Center of cahol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

Interested? Complete and mail this coupon to:
Dept. SERENTIL/Sandoz Pharmaceuticals
Route 10/Hanover, N. J. 07936

SANDOZ



Dr. _____
(PLEASE PRINT)

Street _____

City _____ State _____ Zip _____

See next page for prescribing information.

SERENTIL®
(mesoridazine)
new weapon in the fight against alcoholism

INDICATIONS: In clinical studies, Serentil (mesoridozine) hos been faund useful in the following disease states:

Alcahalism—Acute ond Chronic: Serentil ameliorates anxiety, tension, depression, nousea ond vamiting in both ocute ond chronic olcahalics without producing hepotic dysfunctian ar hindering the functionol recovery of the impaired liver.

Schizaphrenia: Serentil is effective in the treatment af schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Canceptual Disarganization, Anxiety, Tension, Hallucinatary Behavior, Suspiciausness and Blunted Affect in schizaphrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect af Serentil wos found to be excellent or gaad in the management af hyperactivity and uncooperativeness associated with Mental Deficiency ond Chranic Brain Syndrome.

Psychaneuratic Manifestatians: Serentil reduces the symptams of onxiety and tension, prevalent symptams often associoted with neuratic campanents af many disorders, ond benefits persanality disorders in general.

CONTRAINDICATIONS: As with ather phenathiazines Serentil (mesoridazine) is contraindicated in severe central nervaus system depression or comotase states from any cause. Serentil is contraindicated in individuals who have previously shawn hypersensitivity to the drug.

WARNINGS: Where patients ore participating in activities requiring complete mental alertness (e.g., driving), it is odvisoble to administer the phenothiazines cautiously and to increase the dasage gradually.

Usage in pregnancy: The safety of this drug in pregnoncy has nat been established; hence, it should be given anly when the anticipated benefits to be derived fram treatment exceed the possible risks ta mather and fetus.

Usage in children: The use af Serentil in children under 12 years af age is not recommended, because safe conditions for its use have not been estoblished.

Attentian shauld be paid to the fact that phenathiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related ta Serentil, one should be aware that such changes hove been seen with other drugs af this class.

Because af possible hypotensive effects, reserve parenteral administratian far bedfast patients or for acute ambulatary cases, and keep patient lying down far at least ½ hour after injection.

Leukopenia and/or ogranulacytosis have been attributed to phenathiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotensian were the most prevalent side effects encauntered. Side effects tended to reach their maximum level af severity early with the exceptian af a few (rigidity and mataric effects) which occurred later in theropy.

With the exceptions of tremor and rigidity, adverse reactians were generally faund among those patients who received relatively high doses early in treatment. Clinicol data showed no tendency for the investigotors to terminate treatment because af side effects.

Serentil has demonstrated a remarkably low incidence af adverse reactions when campared with ather phenothiazine campounds.

Central Nervaus System: Drowsiness, Parkinson's syndrame, dizziness, weakness, tremor, restlessness, ataxio, dystania, rigidity, slurring, okathisia, matoric reactians (opisthotonos) have been reparted.

Autanamic Nervaus System: Dry mouth, nausea and vamiting, fainting, stuffy nase, photaphobia, constipotion and blurred vision have occurred in some instances.

Endacrine System: Inhibition of ejaculotion and lactatian have been noted rarely.

Skin: Itching, rash, hypertrophic papilloe of the tangue and angioneurotic edema have been reported.

Cardiavascular System: Hypatension and tachycardia have been reported. EKG changes have occurred in same instances (see Phenothiozine Derivatives: Cordiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficocy, indicatians and untaward effects have varied with the different phenothiazines. The physician shauld be aware that the fallowing have accurred with one or mare phenathiazines and shauld be considered whenever one of these drugs is used:

Autanamic Reactians: Miasis, abstipatian, anorexio, paralytic ileus.

Cutaneaus Reactians: Erythema, exfoliative dermatitis, contoct dermotitis.

Blaad Dyscrasias: Agranulocytosis, leukopenia, eosinophilio, thrombocytopenia, anemia, aplastic anemia, pancytapenia.

Allergic Reactians: Fever, loryngeol edema, angioneurotic edema, asthma.

Hepatataxicity: Jaundice, biliary stasis.

Cardiavascular Effects: Changes in the terminal partian af the electracardiogram, including prolangatian of the Q-T intervol, lowering ond inversion of the T-wave and oppeorance of a wave tentatively identified as a bifid T or a U wave have been observed in same patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). Ta date, these appear to be due ta altered repolarization and not related to myocardial damage. They appear to be reversible. There is no evidence at present that these char are in ony way precursors of ony significant turbance of cardioc rhythm.

Hypotenslon, rorely resulting in cardioc a has been noted.

Extrapyramidal Symptams: Akathisio, agita motar restlessness, dystonic reactions, tri torticollis, opisthotonos, oculogyric crises, tre muscular rigidity, oklnesio—some of whlch rare occasions hove persisted for severol mo or yeors especlolly in potients af advanced with brain damage.

Endacrine Disturbances: Menstrual irregular altered libido, gynecomastia, weight gain. F positive pregnoncy tests have been reparted.

Urinary Disturbances: Retentian, incantinence

Others: Hyperpyrexia. Behavioral effects sug tive of a paradaxical reaction hove been repo These include excitement, bizarre dreams, ag vation of psychoses and toxic confusional st More recently, a peculior skin-eye syndrome been recognized os o side effect fallowing term treatment with phenathiazines. This reac is marked by progressive pigmentotion of a of the skin ar conjunctivo ond/or occompanie discolaration of the exposed sclero and co Opacities af the anterior lens and cornea scribed as irregular or stellote in shope h alsa been reported.

DOSAGE AND ADMINISTRATION: Oral: The age of Serentil (mesoridazine), as in mast cations, shauld be adjusted to the needs af individual. The lowest effective dasage sh always be used. When maximum respons achieved, dosage may be reduced gradual a maintenance level.

Alcahalism: For mast patients the usuol sta dase is 25 mg. b.i.d. The usual aptimum daily dose ronge is 50-200 mg. per doy.

Schizaphrenia: For most potients, regardles severity, a starting dase of 50 mg. t.i.d. is re mended. The usual optimum total daily dose ra is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency Chranic Brain Syndrome: For mast patients a ing dose of 25 mg. t.i.d. is recommended. usual optimum total daily dase range is 75-300 per day.

Psychaneuratic Manifestations: For mast patients usual starting dose is 10 mg. t.i.d. The usual mum total daily dase range is 30-150 mg. per

Injectable Form: In those situatians in which intramuscular form of medicatian is indica Serentil (mesoridazine) Injectable is available mast patients a starting dase of 25 mg. is re mended. The dose may be repeated in 30 t minutes, if necessary. The usual optimum total d dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 and 100 mg. mesoridozine (as the besylate). tles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the b ote)]. Inactive Ingredients—Disodium Ede U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 Carbon Dioxide Gas (Bone Dry), q.s.; Water Injectian, U.S.P., q.s. to 1 cc. Boxes of 20 and

SER70-10

Sandoz Pharmaceuticals, Honover, N.J.

OSMA Specialty Sections

Continued

Section on Pediatrics — Chairman: Charles Q. McClelland, M.D., 20629 North Park Boulevard, Cleveland 44118 (Also President, Ohio Chapter, Amer. Acad. of Pediatrics); Secretary: George A. Smith, M.D., 908 N. Fountain Avenue, Springfield 45504 (Also Secretary, Ohio Chapter, Amer. Acad. of Pediatrics).

Section on Physical Medicine and Rehabilitation—(officers to be announced).

Section on Plastic Surgery — Chairman: John C. Kelleher, M.D., 328 22nd Street, Toledo 43624; Secretary: George A. deStefano, M.D., 250 Wm. Howard Taft Road, Cincinnati 45219; Program Chairman: John L. Terry, M.D., 1100 Morse Road, Columbus 43224.

Section on Psychiatry and Neurology — Chairman: Donald H. Burk, M.D., Harding Hospital, 445 East Granville Road, Worthington 43085 (Also President, Ohio Psychiatric Association); Secretary: Robert J. McDevitt, M.D., 3333 Vine Street, Cincinnati 45220 (Also Secretary, Ohio Psychiatric Association); Program Chairman: Gordon F. Ogram, M.D., State Dept. of Mental Hygiene, 1210 State Office Building, Columbus 43215.

Section on Radiology—(officers to be announced).

Section on Rheumatology — Chairman: Evelyn Hess, M.D., Dept. of Internal Medicine, Cincinnati General Hospital, Cincinnati 45229; Secretary: Joseph E. Levinson, M.D., 2825 Burnet Avenue, Cincinnati 45219; Program Chairman: Vol K. Philips, M.D., 1211 Dublin Road, Columbus 43215.

Section on Sports Medicine — Chairman: Sol Maggied, M.D., 15 East Pearl Street, West Jefferson 43162; Secretary: Sanford Press, M.D., 525 North Fourth Street, Steubenville 43952.

Proceedings of The Council

Meeting of May 15, 1970

The Council met at 8:00 A.M., Friday, May 15, 1970, at the Sheraton-Columbus Motor Hotel. All members of The Council were present. Others present were: John Budd, M.D., Messrs. Stichter, Page, Edgar, Gillen, Campbell, Clinger and Moore.

Committee Appointments Approved

By official action, The Council approved the appointments to the special committees for 1970-1971, as presented by Dr. Richard L. Fulton, President.

Staff Commended

The Council commended the staff on the execution of the Annual Meeting arrangements.

Next Council Meeting

It was announced that the next Council meeting will be held July 18-19, at the Crown Inns Motor Lodge, and that the wives of the Councilors are invited to attend.

The meeting then adjourned.

ATTEST: Hart F. Page
Executive Director

Hematology Seminar Scheduled in Dayton

The Veterans Administration Center in Dayton has scheduled a Hematology Seminar to be held on Wednesday, November 4. The program begins at 8:00 a.m. and ends at 4:30 p.m.

Distinguished physicians serving as faculty will include: William B. Castle, M.D., VA Hospital, West Roxbury, Mass.; Ernest Beutler, M.D., chairman, Division of Medicine, City of Hope National Medical Center, Duarte, Calif.; Emil Frei III, M.D., associate director for clinical research, M. D. Anderson Hospital and Tumor Institute, Houston, Texas; and Stanley P. Balcerzak, M.D., director, Division of Hematology and Oncology, Ohio State University College of Medicine, Columbus.

For further information, interested physicians may contact R. G. Belliard, M.D., Chief, Hematology Section, Veterans Administration Center, 4100 West Third Street, Dayton 45428.



INCREASED COST OF PROVIDING HEALTH CARE FOR THE ELDERLY

The table below indicates the differences in health care expenditures per capita for those under age 65 and those 65 and over. We particularly wish to point out:

1. Per capita costs for all types of expenditures are almost 230 percent more for those 65 and over.

2. Public funds (federal, state and local) pay for 72 percent of the expenditures for the elderly, and 23 percent for those under 65.

3. Physicians' services comprise 15 percent of the total expenditures for the senior citizens and 24 percent of the total for those under 65.

4. Annual hospital costs per capita are almost 260 percent more for those age 65 and over.

5. Annual expenditures per capita for physicians' services are 102 percent more for the elderly.

EDITOR'S NOTE: *This is one of a series of articles, the purpose of which is to inform the membership of pertinent facts about health care. The content will be intentionally brief and will present only a few significant facts in each issue. We trust that readers can thus more easily remember such information and use it as appropriate in discussions with patients and others. "Capsules" are prepared by OSMA Director of Economic Research, Charles F. Price. If you need explanation or elaboration on any of the data, please direct your requests to him at the OSMA office.*

New Rules of the Road — Learn 'em and Live

More than 56,500 men, women and children were killed in highway crashes in 1969, according to the annual highway accident data booklet published by a leading insurance company. The toll was up from the 55,300 killed a year ago.

Excessive speed was the chief cause of death, drivers under 25 years caused a disproportionate number of accidents, three out of four people were killed or injured on dry roads in clear weather, and crossing between intersections was the major factor in the deaths of nearly 10,000 pedestrians.

A growing problem for many drivers is the interstate highway. Seen from an airplane, these ribbons of concrete and tar present an impressive design. But to a driver they can be a trap—a fatal trap.

Many drivers do not know what a "yield" sign really means, or recognize the crucial importance of minimum and maximum speeds, the danger of blocking the outside, passing lanes, or know how properly to change lanes.

Outmoded or improperly designed highways —whether because of terrain or poor judgment —and the lack of a uniform highway sign code tend to confuse drivers. The stranger to a highway slows down while the native zooms by, setting the stage for an accident.

The annual survey asserts that driving on some interstate highways can be likened to a war. The driver must arm himself with concentration, a defensive attitude and a serious study of the new rules of the road.

Estimated Per Capita Health Care Expenditures by Type of Expenditure, Source of Funds, and Age

Fiscal Year 1969

	UNDER AGE 65			OVER AGE 65		
	Private Funds	Public Funds	Total	Private Funds	Public Funds	Total
Hospital care	$ 57.19	$ 28.91	$ 86.09	$ 32.89	$302.39	$335.28
Physicians' services	47.36	5.55	52.91	21.24	85.75	106.99
Other professional services	22.93	1.71	24.64	21.86	5.75	27.61
Drugs and drug sundries	24.66	.79	25.45	70.25	9.24	79.48
Nursing home care	.50	.80	1.30	26.79	84.62	111.40
Other health services	9.20	10.71	19.91	20.01	11.44	31.46
TOTAL	$161.84	$ 48.45	$210.30	$193.04	$499.08	$692.22

SOURCE: Social Security Research and Statistics Note No. 7, 1970.



Investment Prognosis

By Frank Van Holte, Columbus

IT IS NOW generally believed by the masters of the market that we have reached the bottom of the bear market. But the behavior of the stock market in the past year has not only been an unpleasant experience to stockholders, it has also left many of us in shock and despair. Corporate profits will probably continue to show poorly in the second and third quarters of the year, inflation is still unharnassed, unemployment is rising, and other national problems plague our confidence. But a recession has not materialized and in fact, the market has had intermittent signs of life. So, don't put the stock market down as a lost cause. In fact, this is an excellent time for a diagnostic workup of your investment portfolio. Many of us have stocks on our list of holdings that were purchased in the rosy era when speculation was popular and attractive. But the brutal market shakeout of the past year has washed away the foundations and the highfliers came tumbling down. We see exposed in the rubble, the weaknesses of our speculations. Probe deeply into these deflated stocks. Ask your broker to help you evaluate them. Can they come back and how long will it take for them to be restored to health? If the rehabilitation appears to be a long road, it may be wise to take your loss and switch to equities that are in good health—stocks that will recover quickly. Let me suggest a few that are sound—stocks that are depressed in price but not depressed in quality or earnings potential.

American Telephone & Telegraph: This giant utility offers an excellent growth potential as well as providing a generous yield. It is currently selling at its lowest price in the last 10 years. This well-managed company seems certain to show a steady increase in earnings and periodic dividend increases. This company has over 3 million shareholders and I recommend that you join the crowd.

Ralston Purina Co: This company is the largest feed producer in the country and has been expanding its international operations and diversification into pet foods, fishing and seafood interests, breakfast cereals, home and garden products, drive-through restaurants, poultry breeding, egg processing, chemical specialties, agricultural health products, and it is planning even further expansion and diversification. This is an aggressive, well-managed company that offers an inviting growth opportunity.

Columbus & Southern Ohio Electric: This utility is surely an excellent buy at its current depressed price. This company and American Electric Power Co. have agreed to consolidate and the shares are selling at a sizable discount from their value under the exchange offer. However, the consolidation is still awaiting review and decision by the SEC. This stock is attractive even if the consolidation is not approved. This is another prime example of a healthy company that has a remarkable opportunity to show a substantial appreciation in value.

We continue to read of the water pollution problem facing the nation, and we have a tendency to disregard the warnings, as water is one of the most taken-for-granted items in our day-to-day living. You don't miss it unless you run out.

Ohio uses 12 billion gallons of water a day. If you put this amount of water in tank cars, these cars would reach to the moon and back about 9 times. And our usage increases each year. Consider that it takes 95,000 gallons of water to make the steel used in one automobile, or two and one-half pounds of bread require 300 gallons of water. In fact, Ohio ranks 6th among the 50 states in water use. If you exclude Lake Erie, Ohio ranks low in the nation in total area of lakes and reservoirs. Would you believe that only 6 states have less lake or reservoir area? The U.S. has one acre of lakes or reservoirs for each 5⅔ persons—Ohio has 1 acre for each 91 persons.

The State of Ohio is fortunate, however, in the fact that it has about 38 inches of rainfall annually. But we lose two-thirds of this water through evaporation and transpiration. The important factor in the Ohio water problem, however, is the fact that we discharge into Ohio streams and lakes, almost 3 billion gallons of waste-carrying water per day. This includes sewage from cities and wastes from industry. So all of us must be concerned, and do our part in cleaning up our waters. As citizens, we must employ the technology available to clean up our water. As investors, we have the opportunity to invest in companies producing products which are an important part or service of this technology. It seems to me that owning a share of such companies should be a part of every long-term growth portfolio.

This monthly feature is written for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Activities in the Counties...

Ashtabula Society Gives High School Award

The Star-Beacon, of Ashtabula, reported that Mark Fickenscher, senior at Jefferson Area High School, received two outstanding honors at the annual awards program at the high school. He was presented the Sabin Award sponsored by the Ashtabula County Medical Society for being the outstanding science student. He also was named recipient of the Baush and Lomb Honorary Science Award for being the science student contributing the most to the high school.

Hardin County Physicians Back Immunization Programs

Early in the spring an epidemic of rubeola broke out in Hardin County. The Hardin County Medical Society gave immediate support by endorsement, publicity, and assistance in an immunization program throughout the parts of the county to which the epidemic had not yet spread.

The county health commissioner considered the program so outstanding that, in view of the excellent response, a similar program for rubella immunization was instituted, with the backing of the Society.

Another local project in which the Medical Society cooperated was the formation of a county Disaster Planning Commission and efforts to bring the local disaster plans up to date.

Biology Professor Honored by Summit County Society

At least a fifth of the practicing physicians in Summit County owe a part of their medical education to Dr. Walter Charles Kraatz, retired head of the Biology Department at Akron University. The Summit County Medical Society, 76 of his former students and others honored the 83-year-old doctor with the society's first Certificate of Professional Recognition.

For 35 years Dr. Kraatz taught at Akron University, starting in 1924. He was named head of the department 10 years later and is credited with starting the school's program for pre-med basic education in biology.

The certificate is the first of its kind to be awarded a nonphysician in the history of the society, which was founded in 1842. Dr. Kraatz retired as professor emeritus of biology.

The award is for "special services to student physicians and to the people of Summit County in the practice of adult education in biology and public health."

Working to expose quackery in the medical profession since his retirement, Dr. Kraatz also is one of the leaders who pushed for fluoridation of Akron water.

Dr. Millard C. Beyer said letters from Kraatz's former students will be placed into a book and presented to him.

S. H. Mountcastle, executive secretary for the society, said that most of the senior staff at the five area teaching hospitals studied under Dr. Kraatz.

—*Akron Beacon Journal,* June 4

Occupational Health Congress Scheduled in Los Angeles

The American Medical Association's Council on Occupational Health has announced the 30th Annual Congress on Occupational Health to be held at the Century Plaza Hotel, Los Angeles.

The program begins at 9:00 a.m. on Wednesday, September 30, and concludes with a discussion period at 4:00 p.m. on Thursday, October 1. Details of the program may be obtained by writing to the Congress at the AMA headquarters, 535 N. Dearborn Street, Chicago, Illinois 60610.

The Congress program is acceptable for 12½ elective hours by the American Academy of General Practice.

The AMA Council on Occupational Health advisory conference with state and county occupational health representatives will meet on Tuesday morning, September 29. The 1970 Western Industrial Health Conference will present two days of scientific sessions, October 2-3, in the same hotel.

Christopher A. Colombi, M.D. has been elected president of the 64-member Board of Medical Consultants to the Safety Department of the City of Cleveland. Dr. Colombi is vice-president of medical affairs with Medical Mutual of Cleveland, Inc. (Blue Shield).

Highlights in Ohio Welfare

Presenting the Professional Consultants
Also, Guidelines on Payment for Physicians

THE Ohio Department of Public Welfare, on a trial basis, has been offered the opportunity to portray to physicians the Ohio Welfare scene and its many complexities and ramifications. A page in *The Journal* will be devoted for the next few months to the problems of welfare and how they affect the medical community. In this era of a purported health crisis, improved communication between health professionals and agencies is essential.

We hope to outline to the physician our structure, philosophy, and goals, and to explain new legislation as it appears. The Division of Medical Assistance, Ohio Department of Public Welfare, includes a multidisciplinary consulting staff representing all the major specialities and it is our desire to share with you the function and responsibilities of this Division. We trust this page will be of interest and value to you and that a productive relationship between your community and our organization will develop.

As physicians in this state are well aware, the Ohio Department of Public Welfare is presently paying for medical services at 60 percent of the physician's usual, customary and reasonable fee. Recently, the Department of Health, Education and Welfare issued guidelines which made it possible to increase payments to physicians for medical services provided to welfare recipients.

Simply put, the payment guidelines provide that the rate of payment for any single medical service may not exceed the amount that was charged by 75 percent of the physicians in Ohio for that service in January 1969. The Federal statement of policy does allow a percentage increase in accord with the Consumer Price Index, adjusted to exclude the medical component.

The Department of Public Welfare has been working toward putting the changes into effect since February.

To arrive at fees equivalent to the required seventy-fifth percentile, it is necessary to formulate a "profile" of payment of physicians' billings submitted during the month of January 1969 for services rendered to welfare recipients.

Information in this column was furnished to *The Journal* by personnel of the Ohio Department of Public Welfare.

OHIO DEPARTMENT OF PUBLIC WELFARE

Division of Medical Assistance

N. J. Bailey, O.D., Ph.D.
B. K. Cole, M.D.
L. H. Cooper, D.P.M.
S. A. Firestone, D.D.S.
J. Fisher, M.D.
E. W. Green, M.D.
W. Grimm, Ph.D.
J. E. Hastings, M.D.
W. M. Haynes, M.D.
C. N. Hoyt, M.D.
W. J. McCloud, M.D.
H. E. McDaniel, D.D.S.
W. D. Paul, M.D.
W. T. C. Sawyer, M.D.
J. W. Schenz, D.O.
M. A. Torch, M.D.
H. E. Williams, M.D.

The Ohio Department of Public Welfare employs the above professional consultants to assist it in the administration of the Medicaid program.

Additional data processing equipment needed to do the job will be installed this summer and it is hoped that full implementation of the plan will be possible by October 1, 1970.

It seems obvious that Ohio physicians and the Ohio Department of Public Welfare will benefit, mutually, if both have a complete understanding of the problem. Such complete understanding will assure a smooth transition from the present 60 percent payment to the new seventy-fifth percentile program—which provides increased payments.

It will be necessary that welfare department personnel be able to readily identify the service provided by the physician. Physicians will be asked to describe medical services in accordance with descriptions set forth in the American Medical Association publication, *Current Procedural Terminology,* Second Edition. Payment of bills will be expedited, if the billings also show the code number since bills otherwise will have to be coded by clerical employees of the department.

Although physicians' individual billing statements will be processed for payment, the department urges physicians to use the billing cards as much as possible. The former will have to be processed manually, as opposed to the latter mechanized process made possible by the use of electronic data processing equipment.

Continuing Education Opportunities for Physicians in Ohio

September

Tests in Ventilatory Function — Trumbull Memorial Hospital, Warren, luncheon program, September 22; David Gillespie, M.D., head, Pulmonary Unit, Cleveland Metropolitan General Hospital, and assistant professor of medicine, Case Western Reserve University.

Fifth Contact Lens Seminar — Department of Ophthalmology, Ohio State University College of Medicine, September 24-26; registration open to ophthalmologists, members of the Contact Lens Society of America, members of the Guild of Prescription Opticians, and technicians recommended by ophthalmologists.

Eleventh Annual Pediatric Postgraduate Conference sponsored by OSU College of Medicine, Department of Pediatrics, and the Columbus Children's Hospital, September 24-25; Contact Center for Continuing Medical Education, OSU College of Medicine, 320 W. Tenth Ave., Columbus 43210.

Ohio Chapter, American College of Surgeons, Neil House Motor Hotel, Columbus, September 25-26; Charles G. Livingood, M.D., Secretary, 211 St. Main Street, Dayton 45402.

October

Brain Tumor Symposium, Ohio State University College of Medicine, October 5-6; recent advances in tissue culture, biochemistry and chemotherapy will be stressed. Contact W. George Bingham, Jr., M.D., program chairman, Division of Neurological Surgery, 410 West Tenth Avenue, Columbus 43210.

Symposium on the Pancreas, Ohio State University College of Medicine in cooperation with the Central Ohio Diabetes Association; OSU Centennial event; October 6-7. Contact Center for Continuing Medical Education, 320 West Tenth Avenue, Columbus 43210.

American Institute of Ultrasound in Medicine, 15th annual meeting, Sheraton-Cleveland Hotel, Cleveland, October 12-15; program chairman, Adnan Sokollu, Sc. D., Office of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Cleveland Course in Pulmonary Disease, Second Annual, St. Luke's Hospital, Cleveland, October 14-15; sponsored by Case Western Reserve University, the Tuberculosis and Respiratory Disease Association of Cleveland, the Ohio TB and Health Association, and the American Thoracic Society. Write Department of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

A Day of Cardiology — Ohio State University College of Medicine, Columbus; October 16, beginning at 9:00 a.m.; contact Arnold M. Weissler, M.D., Department of Medicine, 410 W. Tenth Avenue, Columbus 43210.

Anatominical Aspects of Chronic Respiratory Disease with Clinical Pathological Correlations — Trumbull Memorial Hospital, Warren, luncheon program, October 27; Jerome Kleinerman, M.D., head, Department of Pathology Research and Clinical Pathology, St. Luke's Hospital, Cleveland, and associate clinical professor of pathology, Case Western Reserve University.

November

Hematology Seminar — Veterans Administration Center, 4100 W. Third Street, Dayton, 8:00 a.m. to 4:30 p.m., November 4. Contact R. G. Belliard, M.D., Chief, Hematology Section, at the center.

Inappropriate Breathlessness - Dyspnea — Trumbell Memorial Hospital, Warren, luncheon program, November 24; George W. Wright, M.D., head, Department of Medical Research, St. Luke's Hospital, Cleveland, and associate clinical professor of medicine, Case Western Reserve University.



l, Dr. Cunningham! I was just telling Herbert
ıould talk to you about my allergy.
:t my nose starts to tickle and..."

w the rest of the story. Sneezing. Watery eyes. se. And for prompt relief of these symptoms, ovahistine® LP. These continuous-release tablets asoconstrictor-antihistamine formulation that orking in minutes, then continues to provide hours. Even when nasal congestion is due to allergic episodes, two Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

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When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

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Ohio Chapter, ACS Announces Columbus Meeting

The Ohio Chaper, American College of Surgeons, will hold a meeting and program on September 25 and 26 in the Neil House Motor Hotel in downtown Columbus.

Saturday, September 26 is the day of the OSU-Texas A & M football game. Persons wishing program or ticket information are invited to write: Wesley Furste, M.D., Program Chairman, 3545 Olentangy River Road, Columbus 43214.

Persons interested in membership blanks should write: Charles G. Lovingood, M.D., Secretary, Ohio Chapter, ACS, 211 South Main Street, Dayton 45402.

Friday Morning, Sept. 25

Introductory remarks
Prize winning papers of residents' essay contest
Ohio Chapter breast survey
How I operate for cancer
- Stomach
- Pancreas
- Cecum and right colon
- Cervix

Ohio Chapter professional liability survey
Fellowship luncheon

Friday Afternoon

Audio-visual presentation of an upper abdominal operation at the Ohio State University Hospital
Drug therapy of tumors
- Thyroid gland
- Breast
- Gastrointestinal tract
- Infant and children

The annual Ohio Chapter oration:
- Cancer and the surgeon

Gynecology
- The Papanicolaou smear
- Young adult female reproductive tract tumors
- The androgen hormone in the female
- Hysterectomy (motion picture)

College activities: An audio-visual presentation for nonmembers, wives, residents, interns, and medical students
Business meeting
Friday evening: Reception and banquet

Saturday Morning, Sept. 26

Breakfast and panel discussion on postgraduate education
Recent advances in surgery
- Basic surgical research
- Gastrointestinal tract
- Otolaryngology and maxillofacial surgery
- Cancer



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during June. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

FRANKLIN
Lawrence A. Gould, Columbus
Nye R. Larrimer, Columbus

SUMMIT
Felicisimo N. Buenafe, Jr., Akron

TRUMBULL
Manuel F. Castaneda, Warren
Richard D. Shapiro Warren

Two Booklets Available in Heart Monograph Series

Two new booklets have been issued in the American Heart Association's Monograph Series as follows:

Volume 27, "Research on Acute Myocardial Infarction," reports on a symposium to identify and promulgate promising concepts for investigation in the still unknown areas of the disease. The many disciplines represented produced promising ideas for the direction of research and reduction of deaths. The volume was edited by Stuart Bondurant.

Volume 28, "Mass Field Trials of the Diet-Heart Question—Their Significance, Timeliness, Feasibility and Applicability,' 'is an assessment of seven proposed experimental designs by the National Heart Institute's Diet-Heart Review Panel, chaired by Edward H. Ahrens.

The new volumes may be purchased through local Heart Associations or from the Association's Central Office, 44 E. 23rd St., New York, N.Y. 10010.

ON THE OMPAC FRONT

Others Influence Elections, Why Not Physicians?

Physicians, who are being asked to make contributions to the Ohio Medical Political Action Committee and its national counter-part, AMPAC, and being urged to make politics an avocation, may be interested in knowing what organizations representing other professions, businesses and working people are planning so far as the 1970 elections are concerned. Following is one example:

The recent biennial convention of the AFL-CIO which sponsors COPE as its political big gun, adopted a resolution reading in part:

"The 1970 congressional elections loom as the most vital in recent years, and as a strong challenge to the political action and education capabilities of the labor movement. . . .

"Thus, it becomes imperative that the present liberal strength in Congress be increased in the 1970 elections to assure that (1) progressive proposals will have a better chance of enactment, and (2) restrictive measures against trade unions and efforts to roll back the social-welfare progress of the past several years will be stopped.

"Clearly, the political stakes are high in 1970, and an extraordinary effort by trade unions in the political education and political action fields is demanded. Therefore, be it

"Resolved: That this convention of the AFL-CIO urge all affiliated unions to call upon their staff, their regional and local union officials, and their members to make political action a preeminent part of their 1970 program; and be it further

"Resolved: That this convention urge all affiliated unions to assign as many full-time staff members as possible to political action and education efforts at the earliest possible date; and be it further

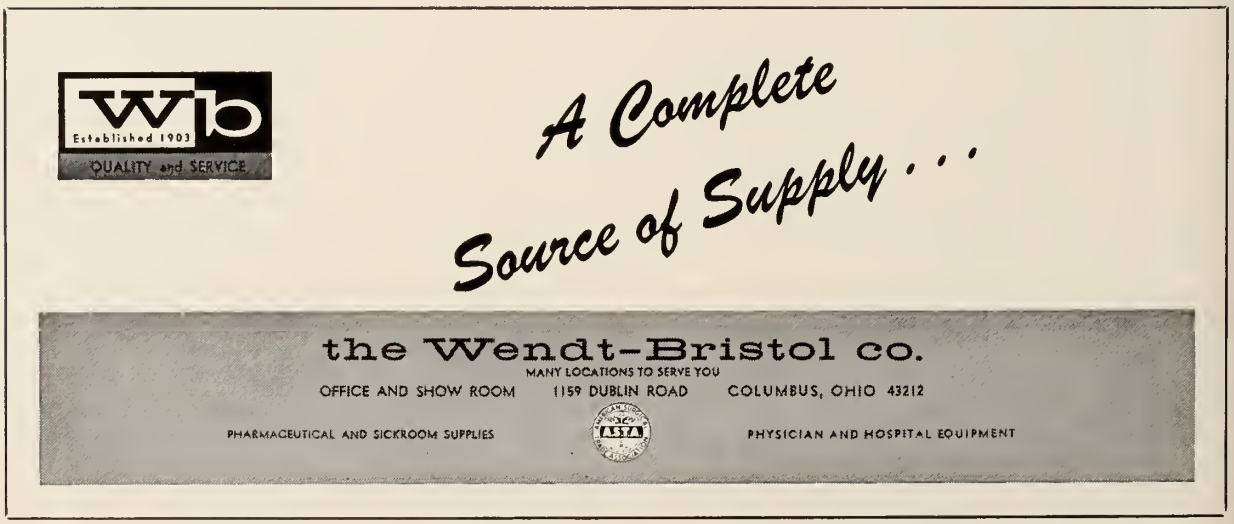
"Resolved: That this convention urge all affiliated unions to cooperate fully in COPE registration and get-out-the-vote campaigns and to meet and, if possible, exceed their COPE voluntary dollar quotas in 1970; and be it further

"Resolved: That this convention urge all affiliated unions, their officers, staff persons and their members to cooperate with COPE in every possible way to assure the most effective labor political programs ever in 1970."

A proposal that all National AFL-CIO COPE congressional endorsements have attached thereto a minimum financial contributions of $2,500.00 was referred to the executive council for consideration.

The 1970 political pot is boiling. A great deal hinges on the outcomes of the elections this coming November. Each physician owes it to the nation, his state, his profession and to himself to take an active part in supporting well qualified candidates for the public offices which will be filled at the November elections. It is quite obvious that other groups have launched their political campaigns. Action now by the medical profession is imperative.

—*Ohio Medical Political Action Committee*



Columbus Physician Appointed to State Medical Board

GOVERNOR James A. Rhodes recently appointed Henry G. Cramblett, M.D., of Columbus, to membership on the State Medical Board of Ohio. He was named to fill the unexpired term of Lloyd R. Evans, M.D., who resigned after serving four years on the Board. The term expires in 1973.

The State Medical Board is the state agency charged with the responsibility of licensing physicians and other practitioners of the healing arts in Ohio and enforcing the law as it applies to the healing arts.



Dr. Cramblett

Dr. Cramblett is professor and chairman of the Department of Medical Microbiology, Ohio State University College of Medicine, and executive director of Children's Hospital Research Foundation. He is a diplomat of the American Board of Microbiology, diplomat of the American Board of Pediatrics, Fellow of the American Academy of Microbiology, and Fellow of the American Association for the Advancement of Science.

Among appointments, he is secretary of the Faculty, OSU College of Medicine, is on the OSU Research Council, and OSU Graduate Council, is on the Clinical Research Fellowship Committee of the National Institutes of Health, and is consultant to the Seminar Services Division of the National Communicable Disease Center.

Dr. Cramblett was born in Scio and received his early education in the Harrison County community schools. He graduated Magna Cum Laude from Mount Union College, and was pledged to Psi Kappa Omega Scholastic Fraternity. Other collegiate honors included affiliation with Phi Sigma (Biology) and Alembroic (chemistry). He received his M.D. degree from the University of Cincinnati College of Medicine in 1953 and again earned several honors, among them the Eben J. Carey Award in Anatomy, the Stella Feis Hoffheimer Scholastic Award, and the pledge to Alpha Omega Alpha.

Dr. Cramblett took his internship in medicine at Boston City Hospital on the Harvard Medical Service. Before coming to Columbus, he was successively resident in pediatrics at Children's Hospital, Cincinnati; chief resident and instructor in the Department of Pediatrics, State University of Iowa; assistant professor at the same institution; associate professor of pediatrics, associate in pathology and microbiology, and director of the Virology Laboratory, Bowman Gray School of Medicine.

In addition to the honors mentioned, Dr. Cramblett is affiliated with numerous professional organizations, among them the Ohio State Medical Association and the American Medical Association.

Other members of the State Medical Board are Frederick T. Merchant, M.D., Marion, president; Ralph K. Ramsayer, M.D., Canton, vice president; Henry A. Crawford, M.D., Cleveland; Peter Lancione, M.D., Bellaire; John D. Brumbaugh, M.D., Akron; W. Thomas Washam, M.D., LL.B., Columbus; and James O. Watson, D.O., Columbus. Mervin F. Steves, M.D., is executive secretary.

Lexington Course Offered on Pulmonary Function Tests

On September 17 through 19, 1970 a postgraduate course on "Pulmonary Function Tests in Management of Chest Disease" will be held at the University of Kentucky Medical Center. This course is planned for physicians and technicians who have some responsibility for intensive care units and patients with chest disease. A $35 fee will be charged. For further information contact Frank R. Lemon, M.D., Associate Dean, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Obituaries

Richards Ellison Amos, M.D., Akron; University of Michigan Medical School, 1915; aged 79; died June 14; former member of the Ohio State Medical Association; practitioner of long standing in the Akron area and former Summit County coroner; past president of the Summit County Medical Society, and active in numerous community projects; veteran of World War I; survived by his widow, two sons, and a daughter.

William Allen Avery, M.D., Granville; Western Reserve University School of Medicine, 1934; aged 64; died May 25; member of the Ohio State Medical Association and the American Medical Association; practitioner in Licking County from 1935, first having his office in Alexandria and since 1948 in Granville; member of the Baptist Church, the Masonic Lodge, and the Rotary Club; survived by his widow, a daughter, two sons, and a sister.

John Anthony Bernard, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1922; aged 78; died June 17; practitioner in Cincinnati for some 48 years before his retirement; member of the Elks Lodge; survived by his widow, two daughters, a brother, and three sisters.

Paul Axtell Bunn, M.D., Syracuse, N.Y.; University of Cincinnati College of Medicine, 1941; aged 55; died May 26; left Ohio after training at University Hospital, Cleveland; recently medical director for the General Electric Company in Syracuse; survived by his widow, a son, and two daughters.

Hugh Carlton Dorr, M.D., Columbus; Ohio State University College of Medicine, 1939; aged 58; died June 10; member of the Ohio State Medical Association, the American Medical Association, and the Aerospace Medical Association; veteran of World War II and practitioner in Columbus since 1946; son of the late Dr. Hugh H. Dorr; member of the Franklin Flyers Club and the Aircraft Owners and Pilots Association; member of the Catholic Church; survived by his widow, four daughters, his mother, two brothers, and a sister.

Jesse Eisen, M.D., Columbus; University of Illinois College of Medicine, 1950; aged 51; died June 20; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Surgery; practitioner in Columbus, specializing in surgery; member of the Temple and B'nai B'rith; survived by his widow, a son, a daughter, and his father.

Viola Janet Erlanger, M.D., San Diego, Calif.; Women's Medical College of Pennsylvania, 1915; aged 78; died May 27; practitioner in Cleveland years ago.

Floyd Milton Green, M.D., Columbus; Ohio State University College of Homeopathic Medicine, 1919; aged 82; died June 3; member of the Ohio State Medical Association and the American Medical Association; practitioner of long standing in Columbus before his retirement; medical director for the Mutual Life Insurance Company; member of the Community Church; survived by his widow, a son, a brother, and a sister.

Sidney Joseph Heeley, M.D., Mt. Pleasant; Ohio State University College of Homeopathic Medicine, 1915; aged 82; died May 21; general practitioner in Eastern Ohio for some 54 years; member of the Methodist Church; survived by his widow and a daughter.

Albert Hirsheimer, M.D., Dayton; Harvard Medical School, 1931; aged 64; died June 6 as the result of a traffic accident; member of the Ohio State Medical Association, the American Medical Association, and the Central Association of Obstetricians and Gynecologists; Fellow of the American College of Obstetricians and Gynecologists; diplomate of the American Board of Obstetrics and Gynecology; practitioner in Dayton since 1937, specializing in obstetrics and gynecology; member of the Episcopal Church and active in a number of community projects; veteran of World War II; Mrs. Hirsheimer was injured in the same accident with her husband; other survivors are a daughter, a son, two brothers, and a sister.

Lloyd Lavern Kersell, M.D., Lancaster; Ohio State University College of Medicine, 1925; aged 68; died May 20; member of the Ohio State Medical Association; practitioner in the

Lancaster area since the early 1930's; Fairfield County health commissioner since 1948 and county coroner since 1957; veteran of World War II; survived by his widow, two sons, a daughter, and two brothers.

Edwin Roosevelt King, M.D., Cleveland; Howard University College of Medicine, 1945; aged 56; died June 10 in a traffic accident; member of the Ohio State Medical Association; diplomate of the American Board of Urology; practitioner in the Cleveland area for a number of years, specializing in urology; served as a captain in the Army from 1951 to 1953; survived by his widow, a daughter, and two sons.

Earl Augustus Martin, M.D., Cincinnati; Western Reserve University School of Medicine, 1913; aged 85; died June 1; career public health officer and Veterans Administration medical officer in Cincinnati and in Washington, D.C.; former member of the Board of Veteran Appeals; recently associated with St. Francis Hospital in Cincinnati; survived by his widow, a step-daughter and four step-sons.

Paul Barkley Newcomb, M.D., Defiance; University of Cincinnati College of Medicine, 1921; aged 76; died June 13; member of the Ohio State Medical Association and the American Medical Association; practitioner in Defiance for 48 years; member of the United Methodist Church, the Masonic Lodge, and the Elks Lodge; survived by a daughter.

Roy C. Rounds, M.D., Dayton; University of Wisconsin Medical School, 1938; aged 61; died June 5; member of the Ohio State Medical Association, and the American Academy of Orthopaedic Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery; practitioner in Dayton since 1953, specializing in orthopaedic surgery; previously headed the Wright-Patterson Air Force Base hospital's orthopaedic department, and later a consultant there; served in the Army Medical Corps during World War II and attained the rank of colonel; survived by his widow, a daughter, four sons, his mother, and five brothers.

Joseph Art Skaggs, M.D., Celina; University of Louisville School of Medicine, 1958; aged 40; died June 25 in the crash of a private plane; member of the Ohio State Medical Association and the American Medical Association; general practitioner in the Celina area since 1959; Mrs. Skaggs died as a result of the same accident; two sons survive, one of whom was in the accident but sustained only minor injuries.

Austin Stanley Weisberger, M.D., Cleveland; Western Reserve University School of Medicine, 1941; aged 56; died June 20; member of the Ohio State Medical Association, the Association of American Physicians, Central Society for Clinical Research, American Society for Clinical Investigation; Fellow of the American College of Physicians; diplomate of the American Board of Internal Medicine; distinguished clinician and recognized worldwide for his investigations in hematology; director of the Department of Medicine and the John Huntington Hord professor of medicine at Case Western Reserve University; member of the Board of Directors of the Academy of Medicine of Cleveland and named man-of-the-year in 1967 by the Academy for his role in exposing a proposed cancer vaccine; served in the Naval Medical Corps during World War II; survived by his widow, three daughters, two brothers, and two sisters.

Daniel Jacob Whitacre, M.D., Columbus; Ohio State University College of Medicine, 1930; aged 65; died June 18; former member of the Ohio State Medical Association; general practitioner in the Linden area of Columbus for some 35 years before his retirement; former athlete and active in school sports; member of several Masonic bodies, and the Christian Church; veteran of World War II; survived by his widow, two sons, and a sister.

Chest Physicians to Meet in Los Angeles

The American College of Chest Physicians will hold its Second Fall Scientific Assembly in Los Angeles at the Century Plaza Hotel, October 25-29. Theme of the program will be the encouragement of multidisciplinary approach to patient care in the areas of pulmonary and cardiovascular diseases.

Details may be obtained by writing Alfred Soffer, M.D., Executive Director, American College of Chest Physicians, 112 E. Chestnut Street, Chicago, Illinois 60611.

Woman's Auxiliary Highlights

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati 45243

COUNTY AUXILIARY presidents, officers and chairmen: Hunt up your fall calendars and draw a big green circle around Tuesday, September 29. That is the day for our **Fall Fact Forum,** your opportunity to meet state officers and chairmen and hear about the year's outline of activities. Plan to come to the Crown Inns in Columbus for a day of fun and fellowship to start you off on a year of action. Remember, Mrs. Carl F. Goll, our new state president, has charged us: "The color is green—the sign is GO—take action!" Details of the Forum's program will be sent to you by the president-elect, Mrs. R. L. Wiessinger, soon.

National Convention Report

Our immediate past president, Mrs. S. L. Meltzer, graciously agreed to again serve as our reporter for the national meeting which was held in Chicago late in June. Here is her letter, written as only Ruth can write.

Dear Fran (and all Ohioans):

I've been trying to recall the words of "Chicago" (the song, that is!). The melody is haunting me but the only words I can come up with are "it's a wonderful town". . . . Well, let's leave it at that, in setting the scene for the 1970 convention of the Woman's Auxiliary to the American Medical Association, June 21-25, at the Drake Hotel. This year's theme was "Up, Up and Away."

The meeting was presided over by Mrs. John M. Chenault, president. I'm not absolutely sure about this, but I believe this is the first time in National's 47-year-old-history that the same woman has presided over two consecutive national conventions. The tragedy last year (Esther Long's death) put upon Belle Chenault's shoulders the double responsibility. In her gracious and efficient manner, she met the challenge superbly.

The Drake, on the shores of Lake Michigan, lends itself well to a large meeting. It's a lovely place with excellent facilities and food par excellence (which didn't help those counting calories). Even the weather cooperated for the most part, although Chicago remained true to its name of Windy City.

Sunday evening, June 21, featured the reception for Mrs. Chenault and Mrs. R. C. L. Robertson, national president-elect, in the Gold Coast Room of the Drake. The hors d'oeuvres were sheer culinary artistry (and my weakness!). The reception proved a wonderful time for greeting and meeting doctors' wives from all over these United States. It's a particularly gratifying experience—that privilege of "getting to know you."

The formal opening of the Forty-seventh Annual Convention took place on Monday morning at 9 a.m. But the 18 Ohio delegates were "bright-eyed and bushy-tailed" at 7:30 a.m. when they gathered for the traditional Ohio Breakfast, that very special occasion each year at National Convention. Dru Goll, our new president, presided over that in her particularly engaging manner. We wore red carnation corsages, and the flowers in the attractive centerpiece were—well, you guess!

Now back to 9 a.m. and the opening session. There were 339 delegates answering to roll call, with 36 states boasting their full delegation present (Ohio included, but of course). The keynote address was given by Mrs. Louise Bushnell, direc-

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Carl F. Goll
1001 Granard Parkway
Steubenville, 43952

President-Elect
Mrs. Russell L. Wiessinger
2280 W. Wayne Street
Lima, 45805

Past President
Mrs. Samuel L. Meltzer
2442 Dorman Drive
Portsmouth, 45662

First Vice-President
Mrs. Rudolf O. Cooks
15830 Van Aken Blvd., Apt. 401
Cleveland, 44120

Second Vice-President
Mrs. Daniel Wolff
3963 W. Bancroft Street
Toledo, 43606

Third Vice-President
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Columbus, 43209

Recording Secretary
Mrs. Emil L. Barrows
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Cincinnati, 45237

Corresponding Secretary
Mrs. F. A. Sunseri
301 Woodridge Drive
Steubenville, 43952

Treasurer
Mrs. Paul Hahn
122 Moore Avenue, N.W.
New Philadelphia, 44663

tor of Women's Activities for the National Association of Manufacturers. Her topic—"Challenge to Women in the 70's." She is a powerful speaker and she prefaced her remarks by saying that it was a challenge to face an audience of do-ers and a delight to meet a clean, decent, hard-working group of women. "In fact", said Mrs. Bushnell, "it's hard to believe."

She went on to say: "By the services you render, you are unbeatable. Your virtues annoy your critics. You are instantly 'suspect' in the eyes of those engaged in isms. . . . Since when does any group of women need to be liberated by her so-called sisters?" Mrs. Bushnell suggested that we "clean the cerebral cobwebs." She spoke of re-underlining the importance of the volunteer in the American way of life. "Stand very tall, let your actions speaker louder than words," she urged.

The annual luncheon on Monday in honor of AMA officers, trustees and wives was designated the "Heavenly 70's." The big moment of the luncheon was the presentation by Mrs. Chenault of the Auxiliary's AMA-ERF contribution for the 1969-70 year to Dr. Robert C. Long, AMA-ERF president.

It was a whopping check in the amount of $498,950.69—just about a thousand dollars less than half a million! This was the largest single contribution the National Auxiliary has yet made. California received an award for the largest amount received from a state auxiliary—$72,000. Ohio ran second with $41,283, but no award, I'm sorry to say.* (California has a membership almost double that of ours.) Ohio's contribution this year was the largest it had ever made.

Awards were given **regionally** on the basis of the largest per capita, and on the largest increase over last year, but not on the largest amount. If that too had been given regionally, we would have been in the "winner's circle." My hat's off to the state of Maryland which, with a membership of only 967, made an AMA-ERF contribution of $29,492.45—an almost unbelievable accomplishment to my way of thinking.

Monday afternoon featured the first of the "Idea Exchange" with participation by the Southern and North Central Regions. As Ohio's immediate past president, it was my privilege to give the two and a half minute Ohio report. Highlighted were the Self-Defense for Women program and the 13-week Health Reporter TV-Radio series. Also mentioned was Ohio's accomplishment in 1969-70 in raising $31,850 for Health Career Scholarships and Loans, $41,283 for AMA-ERF, $10,000 for mental health activities and $2500 for Project Hope—a grand total of $85,-633.00!

Ohio's booth at the "Show and Tell" exhibit featured the two projects described in the oral report plus a display of our various publications. We distributed mimeographed copies of the Self-Defense brochure as well as those of the TV-Radio series. Considerable interest was evidenced in these projects (virtually all of our mimeographed copies were "gobbled up"!)

Tuesday's luncheon continued to carry a Heavenly "tint." This time it was designated "Stars Always Shine." (I'm so glad our convention came first with its "Out of This World" theme!) The program, "Woman Through History," was outstanding. It was a pageant of fashion down through the ages with original and authentic reproductions of costumes and hair styles, make-up, jewelry and accessories from 22 countries, against a background of music, slides and narration. This most unusual "style show" was presented by the sponsors of the Kenosha (Wisconsin) Homemakers Home Health Aid Service. It was breathtakingly beautiful, original and captivating.

That afternoon highlighted an important seminar on drug abuse. There was active participation between the experts of the panel and our delegates in a question and answer session following the presentation.

The installation of new officers and directors was Wednesday morning's piece de resistance. In her inaugural address, Mrs. R. C. L. Robertson, our new national president, emphasized the importance of what the doctor's wife can do in her local auxiliary. "Auxiliary members must take active leadership in their individual communities," she said. She quoted President Nixon's "success lies in the one-to-one relationship." She advised auxiliary members to open their eyes and educate their hearts. She told of the addition of physical fitness to the auxiliary program for 1970-71.

It was our own Gerby Ritter, National Past President, who presented Mrs. Chenault with her past president's pin. Gerby's warmth and graciousness has a way of making the simplest ceremony memorable.

I mustn't overlook mention of another of Ohio's outstanding past presidents—Ludel Sauvageot—who conducted an excellent conference for State Editors. Ludel will continue to serve on the National Board as Communications chairman. I don't know of anyone better fitted for that important job.

The afternoon session on Wednesday was devoted to the new physical fitness program. Dr. Fred L. Allman, Jr. of Atlanta, Georgia, who is a member of the AMA committee on physical fitness, spoke on the topic "Prescription for Better

*See heading: A Long Distance Postscript

Living". Dr. Tenley Albright of Boston, former U.S. figure skating champion, discussed the women's viewpoint. During the question and answer period it was emphasized that doctors should, themselves, participate in the physical fitness program. Wives should encourage their husbands to take an active part as individuals.

I'm well aware that I've barely scratched the surface in this capsule on National Convention. Listening to the reports of the other states gives one a keen awareness of the remarkable services performed by the medical auxiliaries. And it makes a doctor's wife mighty, mighty proud to be a member of the auxiliary team. If I attempted to give all the business that was transacted, I'd be writing the minutes—and far be it from me to take that job away from the recording secretary! There were the serious moments, and there were the fun moments. After all, what's that about all work and no play????

Marshall Fields, Saks Fifth Avenue, Walgreen's, the Empire Room at the Palmer House, the Merchandise Mart, etc., etc., weren't on the convention agenda. But you can bet they (and many, many other places) were on our personal agendas! (individuals).

And, speaking of individuals, here are the eighteen delegates who represented Ohio at the national convention:

Mrs. Samuel L. Meltzer, Presidential Delegate
Mrs. Carl F. Goll, Chairman of Delegates
Mrs. Floyd Beman
Mrs. C. A. Colombi
Mrs. Henry Crawford
Mrs. James Danford
Mrs. Carl Frye
Mrs. Reuben Gould
Mrs. Henry Holden
Mrs. Paul Jones
Mrs. Carl Lincke
Mrs. Richard Mills
Mrs. Eugene Mueller
Mrs. Malachi W. Sloan
Mrs. George Tischler
Mrs. Carl Ulicny
Mrs. Russell Wiessinger
Mrs. John Young

A Long Distance Postscript

So Ruth Meltzer has done it again—taken copious notes during a busy convention in which she herself proudly reported Ohio's accomplishments during the past year—in order to write this column for *The Journal*. I had just finished typing up the report when the phone rang and there was Ruth with an exciting P.S. to the story. She had just received a letter from John M. Chenault, M.D., new president of AMA-ERF, giving Ohio an honorable mention as runner-up auxiliary in the category of largest contributor to AMA-ERF on the national level for the year 1969-70! We are in the "Winner's Circle" after all.

County Report Session

One of the highlights of our state annual meeting is the session devoted to capsule reports of the varied activities of our many counties. There isn't space to present these in full but here are a few of the outstanding achievements of Ohio auxilians in the 1969-70 year.

Allen County's biggest project this year was a new one. They cooperated with the Mental Health Association and the Allen County Social Workers in sponsoring a lecture to the public by Dr. Karl Menninger. Over 1000 tickets were sold!

Belmont County reports the continued success of its annual semi-formal dance which raises funds for AMA-ERF, Project Hope, local and state mental health agencies, library subscriptions for *Today's Health* and Christmas gifts for the state hospital and county home. That's a big list for 29 members!

Along with many other projects, **Butler County** gave prominence to the skit "Let's Get Basic." The performance was given to four different groups, reaching a total of 450 people. A panel consisting of a physician, a lawyer, a minister, and two police officers answered questions after each presentation. Subscriptions to *Today's Health* are given to 25 junior and senior high schools and to 20 different health and community agencies in the county.

Champaign County's energetic 15 members accumulated a total of 2000 service hours to the community through various fund raising campaigns, hospital service, county home visitation, and organization work for church, PTAs, Scouting, etc. They purchased a film on Venereal Disease for the local Board of Education which was shown in several county schools.

Clark County's annual Gardenia Sale supports an ambitious nurse scholarship program. The $1500 raised in the twentieth year of the program is being used to assist four students. The committee, which involves most of the members of the auxiliary in one way or another, had a new duty this year—the packaging of the 3000 flowers to be sold!

Clinton County boasts 100 percent membership and concentrates on local activities such as the work of the County Hospital Guild. In place of the annual Christmas Tea for hospital personnel, auxilians took attractive trays of homemade cookies to each station, office, laundry, etc. with a card extending greetings from the auxiliary. Everyone seemed to like this new approach.

Coshocton County's 14 members are conscious of their responsibilities in community affairs and serve on the boards of several organizations. They value their auxiliary membership as a

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source of friendship and rapport in the medical community.

Columbiana County, with a membership of 70, celebrated its 30th anniversary. The money raised at an International Bazaar supports a number of projects. An annual event is the Rose Luncheon each May.

Cuyahoga County's president stated that so many individuals have contributed their talents and devoted service toward the success of the auxiliary program that it is impossible to give proper recognition. The primary effort this year was in education on the problems of drug abuse. Included were a seminar for educators, a luncheon for community leaders, and a radio show for the general public.

Darke County auxilians (another 100 percent group) are unusually active in church, school, philanthropic and cultural activities with their families, and in the health oriented organizations especially. They do not participate in special auxiliary projects but meet four times yearly.

Delaware County reports a successful year of revival after two years at low ebb. More regular meetings, a review of objectives and a reemphasis on the "world" of medicine resulted in more participation in auxiliary affairs. They are making a real effort to keep their small group (19) active in deed and in spirit.

Erie County reports that "after a year of self-analysis and evaluation, the members responded beautifully when it was shown that their services were indeed a valuable contribution to the community." In fact, several programs were expanded over previous years.

Fairfield County auxilians worked in a number of areas but were especially active in promoting paramedical careers. They helped six Health Career Clubs in their program planning, provided high school counselors with information concerning scholarships, etc., and cooperated with teachers in planning a career day. They also provided a Paramedical Scholarship Loan for a first year student.

Franklin County's most outstanding program of the year involved all the Interest Groups of the auxiliary—The Gourmet Group, Glee Club, and Craft Group. The meeting rated good news coverage and attracted a large crowd. The Nurse Scholarship project was particularly successful with assistance being granted to six student nurses.

Geauga County auxilians believe that their first service is to help their husbands, then to assist the community. A dozen of the 19 members work full- or part-time in their husbands' offices since the area is greatly lacking qualified personnel for these jobs! Another R.N. member is an instructor for nurses aides. Still, they find time for community service for fund raising, and for occasional get-togethers for medical families.

Guernsey County's 17 members filled a whole page with an account of their many worthwhile activities. They worked with the Salvation Army in distributing food baskets at Christmas, organized a county Health Careers Club, entertained County Home patients at Easter Time, provided a student nurse scholarship, and assisted the hospital in many ways.

Hamilton County's theme, program, publications and social events were all keyed to increase individual interest and participation with the "Accent on You." A detailed study of the committee structure of the Auxiliary was made and plans outlined for an experiment in restructuring the organization for greater efficiency and productivity.

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County Societies' Officers and Meeting Dates

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High St.

ADAMS—Gary J. Greenlee, President, Farmers' Bank Building, Manchester 45144; Hazel Sproull, Secretary, P.O. Box 337, West Union 45693, 3rd Thursday, April, July, Oct. and Jan.

BROWN—Robert S. Benintendi, President, South Main Street, Route 1, Box N, Georgetown 45121; Robert A. Baker, Secretary, South Main Street, Georgetown 45121.

BUTLER—John H. Varney Jr., President, 3207 Sheldon Rd., Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, P.O. Box 325, 110 North Third St., Hamilton 45011. 4th Wednesday.

CLERMONT—Kurt Platschik, President, 4450 Mt. Carmel-Tobasco Road, Cincinnati 45244; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103; 3rd Wednesday except July, August and December.

CLINTON—Arthur F. Lippert, President, 110 East Locust St., Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday.

HAMILTON—Robert S. Heidt, President, 2340 Auburn Ave., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday, except June, July, Aug. and Dec.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson St., Greenfield 45123.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason 45040; Orville L. Layman, Secretary, 22 West Fourth St., Franklin 45005. 2nd Tuesday.

Second District

Councilor: George J. Schroer, Ft. Loramie 45845
20 S. Main St.

CHAMPAIGN—Lewis Inskeep, President, 201 Scioto St., Urbana 43078; Terrence F. Grogan, Secretary, 848 Scioto St., Urbana 43708. 2nd Wednesday.

CLARK—Wesley E. Knaup, President, 1054 East High St., Springfield 45505; Mrs. Marion Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone St., Springfield 45503. 3rd Monday, except June, July, Aug. and Dec.

DARKE—E. W. Browne, President, 330½ West Fourth Street, Greenville 45331; Giles Wolverton, Secretary, Health Department, Court House, Greenville 45331. 3rd Tuesday.

GREENE—Rudi Sotlar, President, 12 South Limestone Street, Jamestown 45335; Mrs. W. F. Whitt, Executive Secretary, 966 Whitestone St., Xenia 45385. Last Friday of every month.

MIAMI COUNTY—Kenneth Faze, President, 3 Duerr Drive, West Milton 45383; Martha L. Derr, Executive Secretary, P.O. Box 467, Piqua 45356. 1st Tuesday.

MONTGOMERY—Robert A. Bruce, President, 1126 South Main St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. Monthly meeting dates as established.

PREBLE—J. D. Darrow, President, 228 North Barron St., Eaton 45320; J. R. Williams, Secretary, 228 North Barron St., Eaton 45320. No regular meeting date.

SHELBY—George J. Schroer, President, 20 South Main St., Fort Loramie 45845; William F. Mentges, Secretary, 870 South Main Ave., Sidney 45365. 2nd Tuesday of March, June, September and December.

Third District

Councilor: Dwight L. Becker, Lima 45805
1559 Bunker Drive

ALLEN—Alexander C. Reed, President, 819 West North St., Lima 45801; William E. Noble, Secretary, c/o Memorial Hospital, Linden & Mobel Ave., Lima 45804. 3rd Tuesday.

AUGLAIZE—John F. Bowling, President, 1001 Knoxville Rd., St. Marys 45885; Barbara Cummins, Secretary, 310 Perry St., Wapakoneta 45895. 1st Thursday every other month, starting with January.

CRAWFORD—Horace B. Newhard, President, 140 Hill St., Bucyrus 44820; C. Fabrigar, Secretary, 139 Gaius St., Bucyrus 44820. Meeting date variable.

HANCOCK—Robert Brown, President, 868 South Main St., Findlay 45840; Truman S. Smith, Secretary, 145 West Wallace St., Findlay 45840. 1st Tuesday monthly.

HARDIN—Jay Pfeiffer, President, 215 Main St., Kenton 43326; John Hughes, Secretary, 601 Pattison Ave., Kenton 43326. 2nd Tuesday evening monthly.

LOGAN—Donald Wyse, President, Oakhill Medical Association, West Liberty 43357; Douglas W. Beach, Secretary, 1008 North Main St., Bellefontaine 43311. 1st Friday monthly.

MARION—John E. Aiken, President, 1040 Delaware Ave., Marion 43302; Brooks Sitterly, Secretary, McKinley Parkway Dr., Marion 43302. 1st Tuesday monthly.

MERCER—George H. McIlroy, President, 123 East Fayette St., Celina 45822; D. J. Schwieterman, Secretary, Maria Stein 45860. 3rd Thursday.

SENECA—Leroy Cummings, President, 60 Sycamore St., Tiffin 44883; Donald Shanabrook, Secretary, 455 West Market St., Tiffin 44883. 3rd Tuesday evening Jan., March, May, July, Sept. and Nov.

VAN WERT—Thomas R. Wilson, President, Van Wert County Hospital, Van Wert 45891; Robert Scheidt, Secretary, Medical Arts Building, Van Wert 45891. 4th Friday.

WYANDOT—D. P. Smith, President, Pennington St., Sycamore 44882; K. K. Solacoff, Secretary, 777 North Sandusky Avenue, Upper Sandusky 43351. 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43624
316 Michigan St.

DEFIANCE—Jack A. Kane, President, Central Foundry, Defiance 43512; Miss Lois Coffin, Executive Secretary, Defiance Hospital, Defiance 43512. 1st Saturday.

FULTON—R. L. Davis, President, 137 South Fulton St., Wauseon 43567; M. S. Renfrew, Secretary, Lutz Rd., Archbold 43502. Quarterly meetings March, June, Sept. and Dec.

County Society Roster (continued)

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545.

LUCAS—Roland L. Kennedy, President, 4639 Farmington Rd., Toledo 43623; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday,

OTTAWA—Donald F. Loeffler, President, 521 East Second St., Port Clinton 43452; Gordon R. Ley, Secretary, P. O. Box J, Port Clinton 43452. 2nd Thursday evening monthly.

PAULDING—Kirkwood A. Pritchard, President, 119 South Main St., Paulding 45879; Don K. Snyder, Route #2, Paulding 45879. 3rd Monday monthly at the Paulding County Memorial Hospital.

PUTNAM—Arthur P. Daniel, Secretary, 144 North Walnut St., Ottawa 45875. 1st Tuesday.

SANDUSKY—Allen Schaengold, President, 325 South Park Ave., Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday except June, July, and August.

WILLIAMS—P. G. Meckstroth, President, Central Drive, Bryan 43506; S. O. Cooper, Secretary, Central Drive, Bryan 43506. 3rd Tuesday.

WOOD—William Roberts, President, North Baltimore 45872; William F. Lord, Secretary, 950 West Wooster St., Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: David Fishman, Cleveland 44106
10515 Carnegie Avenue

ASHTABULA—W. B. Millberg, President, 430 West 25th Street, Ashtabula 44004; Miss Dorothy L. Geho, Executive Secretary, P.O. Box 205, Geneva 44041. 2nd Tuesday.

CUYAHOGA—Vincent T. LaMaida, President, 4125 Mayfield Rd., Cleveland 44121; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106. Board meets 2nd Tuesday.

GEAUGA—Oscar Brinckmann, President, 12475 Hospital Dr., Chardon 44024; Mrs. Ruth Milgate, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024. 2nd Friday.

LAKE—John J. Cahill, President, 36001 Euclid Ave., Willoughby 44094; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060. 4th Wednesday of Jan., March, May, Sept. and Nov.

Sixth District

Councilor: Maurice F. Lieber, Canton 44703
515 Third St., N. W.

COLUMBIANA—John A. Fraser, President, 403 Little Building, East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460. 3rd Tuesday monthly.

MAHONING—Robert L. Jenkins, Jr., President, 21 Wickliffe Circle, Youngstown 44515; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44505. 3rd Tuesday, except June, July and August.

PORTAGE—Kenneth F. Rupp, President, 9160 State Route 43, Streetsboro 44240; Miss Marie Motyka, Executive Secretary, 430 Grant St., Akron 44311. 3rd. Tuesday.

STARK—Frank O. Goodnough, Room 615, President, Peoples-Merchants Trust Building, Massillon 44646; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday.

SUMMIT—Edwin W. Cauffield, President, 505 Ohio Building, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 2nd Tuesday, excluding July and August.

TRUMBULL—J. R. Phillips, President, St. Joseph's Hospital, N. Tod Avenue, Warren 44485; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday, September through May.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth St.

BELMONT—Thomas L. Ring, President, 3205 Belmont Street, Bellaire 43906; Bertha M. Joseph, Secretary 100 South 4th Street, Martins Ferry 43935. 3rd Thursday, except January, May, July and August.

CARROLL—T. J. Atchison, President, 292 East Main St., Carrollton 44615; Jack L. Maffett, Secretary, 264 South Lisbon St., Carrollton 44615. 3rd Tuesday.

COSHOCTON—Myron Saturski, President, 149 South Bridge Street, Newcomerstown 43832; Robert W. Secrest, Secretary, 1926 Melbourne Road, Coshocton 43812. 2nd Tuesday.

HARRISON—R. W. Weiser, President, Jewett 43986; Janis Trupovnieks, Secretary, Hopedale 43976. Quarterly, March, June, Sept. and Dec.

JEFFERSON—Crist G. Strovilas, President, 812 North Fourth St., Toronto 43964; Mrs. Mary Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952. 4th Tuesday, except Aug. and Dec.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—P. T. Doughten, President, 551 Wabash Ave. N. W., New Philadelphia 44663; M. R. Puterbaugh, Secretary, 104 Iron Ave., Dover 44622.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson Street

ATHENS—Dale Mattmiller, President, Hudson Health Center, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. Second Tuesday quarterly, September, December, March, and June.

FAIRFIELD—R. A. Welsh, President, Lancaster-Fairfield Hospital, Lancaster 43130; C. R. Reed, Secretary, 309 East Main Street, Lancaster 43130. 2nd Tuesday.

GUERNSEY—Merritt C. McCuskey, President, 1200 Edgeworth Ave., Cambridge 43725; Quentin F. Knauer, Secretary, 100 Clark Ct., Cambridge 43725. 1st Tuesday monthly, 7 P.M., Cambridge Country Club.

LICKING—Edward A. Carlin, President, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055; G. Franklin Gabe, Secretary, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055. 4th Tuesday monthly.

MORGAN—Asa Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 East Union Ave., McConnelsville 43756.

MUSKINGUM—James F. Morton, President, 727 Market St., Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Ave., Zanesville 43701. 1st Tuesday.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Box 239, Caldwell 43724. 1st Tuesday.

County Society Roster (continued)

PERRY—A. G. Cruz, President, 203 North Main St., New Lexington 43764; R. E. Herendeen, Jr., 203 North Main St., New Lexington 43764.

WASHINGTON—Gregory B. Krivchenia, President, 326 Third St., Marietta 45750; Donald E. Fleming, Secretary, Vincent 45784. 2nd Wednesday monthly.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—Arturo de Lamerens, President, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631; Donald M. Thaler, Secretary, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631. Quarterly meetings at call of officers.

HOCKING—Lethia W. Starr, President, 109 Mulberry St., Logan 43138; J. W. Doering, Secretary, 42 North Spring St., Logan 43138. 2nd Tuesday monthly.

JACKSON—Earl Levine, President, 120 North Ohio Avenue, Wellston 45692; John M. Cook, Secretary, Box 316, Oak Hill 45656. Meetings when called.

LAWRENCE—A. Burton Payne, President, 411 Center Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly meetings.

MEIGS—Charles J. Mullen, President, 210½ East Main St., Pomeroy 45769; E. Butrimas, Secretary, 204 East Main St., Pomeroy 45769.

PIKE—W. W. Wiltberger, President, 330 East North St., Waverly 45690; Thomas Hwang, Secretary, 300 Cherry St., Waverly 45690. 1st Tuesday monthly.

SCIOTO—Joseph T. Gohmann, President, c/o Scioto County Medical Society, 1805 27th St., Portsmouth 45662; Mr. Lowell Thompson, Executive Secretary, 1805 27th St., Portsmouth 45662. 6:30 p.m. 2nd Tuesday.

VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050
104 E. Gambier St.

DELAWARE—John L. Binkhorst, President, 26 Northwood Dr., Delaware 43015; Lloyd E. Moore, Secretary, Magnetic Springs 43036. 3rd Tuesday except June, July and Aug.

FAYETTE—H. W. Payton, President, 36 South Main Street, Jeffersonville 43163; M. H. Roszmann, Secretary, 1005 East Temple Street, Washington C. H. 43160. 2nd Friday.

FRANKLIN—Philip H. Taylor, President, 3545 Olentangy River Rd., Columbus 43214; Mr. W. "Bill" Webb, Executive Secretary, 17 South High St., Suite 528, Columbus 43215. 3rd Tuesday except June, July and Aug.

KNOX—James R. McCann, President, Medical Arts Building, Mount Vernon 43050; Robert Westerheide, Secretary, Medical Arts Building, Mount Vernon 43050. 1st Wednesday.

MADISON—Brawley Arikawa, President, 176 North Madison Road, London 43140; William T. Bacon, Secretary, 194 Elm Street, London 43140. Four times a year, 2nd Wednesday (3, 6, 9, 12).

MORROW—David James Hickson, President, 712 Baker St., Mount Gilead 43338; Lowell Murphy, Secretary, 209 South Main St., Cardington 43315. 1st Tuesday monthly.

PICKAWAY—H. H. Swope, President, 400 North Court St., Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney St., Circleville 43113. 1st Tuesday except July and Aug.

ROSS—Roy Manning, President, 1 Overlook Dr., Chillicothe 45601; Paul MacCarter, Secretary, 60 Central Center, Chillicothe 45601. 1st Thursday.

UNION—John R. Linscott, President, 225 Stockdale Dr., Marysville 43040; May B. Zaugg, Secretary, Route 5, Timber Trails, Marysville 43040. 1st Tuesday of Feb., April, Oct. and Nov.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Rd.

ASHLAND—William Emery, President, 247 Sandusky Street, Ashland 44805; J. H. Cooperrider, Secretary, 637 North Union Street, Loudonville 44842. 1st Thursday.

ERIE—R. H. Williamson, President, 410 Wasta Rd., Huron 44839; Mrs. Barbara Wolfert, Executive Secretary, 1428 Hollyrood Rd., Sandusky 44870. 2nd Tuesday except July and Aug.

HOLMES—Daniel J. Miller, President, Walnut Creek 44687; Charles H. Hart, Secretary, 109 South Clay St., Millersburg 44654. First (or Second) Thursday 7 P.M. (Sometimes it may follow hospital staff meeting.)

HURON—John E. Rosso, President, 218 Myrtle Ave., Willard 44890; Russell R. Fisher, Secretary, 257 Benedict Ave., Norwalk 44857. 2nd Wednesday of February, April, June, October and December.

LORAIN—Robert P. McFarland, President, Oberlin Clinic, Inc., 224 West Lorain Street, Oberlin 44074; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday for REGULAR MEETINGS. Last Thursday of the month for COUNCIL MEETINGS.

MEDINA—H. E. Grover, President, 146 North Lyman Street, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 943 N. Jefferson Street, Medina 44256. 3rd Thursday.

RICHLAND—Robert W. Jones, President, 120 Sturges Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, c/o Mansfield General Hospital, Mansfield 44903. 3rd Thursday except June, July and August.

WAYNE—Frank Cebul, President, 1740 Cleveland Road, Wooster 44691; Thomas Graves, Secretary, 1740 Cleveland Road, Wooster 44691. 2nd Wednesday of alternate months.

For Roster of OSMA Officers and Committeemen
See Revised Listing in the July Issue

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Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

EXCELLENT OPPORTUNITY: Large industrial private medical practice, Southwestern Ohio, wishes associate. Reply Box 547, c/o Ohio State Medical Journal.

IMMEDIATE OPENING: INTERNIST or General Practitioner to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practicing physicians (General Practitioners) in the community outside of our clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd., Two Rivers, Wisconsin 54241.

GENERAL PRACTITIONER OR INTERNIST—Available immediately. Busy practice for G.P. or Internist desiring family practice without Obstetrics. Group consists of 3 G.P.'s and Surgeon, in new building with lab and x-ray facilities. Local 50 bed J.C.A.H. approved hospital. Rural area with excellent school system. Ready access to Cleveland, Akron, Columbus. No investment. Early partnership. Housing available. Reply John A. Grafton, Business Mgr., Lodi Medical Building, 402 Highland Dr., Lodi, Ohio 44254 or phone (216) 948-1555.

PSYCHIATRISTS: Avoid pollution—enjoy fresh air, clean water, less people in a summer-winter vacationland near Interlochen Arts Academy. Small town peace and quiet. Big city culture and salaries. Progressive psychiatric hospital, J.C.A.H. approved, 3-year Psychiatric Residency Program. Salaries to $32,364 if you qualify, excellent fringes, housing available. Contact M. Duane Sommerness, M.D., Traverse City State Hospital, Traverse City, Michigan 49684.

UNIVERSITY STUDENT HEALTH PHYSICIANS: Two immediate openings, Northwest Ohio, 13,000 students, modern new facilities, 102 bed hospital and complete lab. & x-ray facilities; excellent salary, fringe benefits, vacation, and working conditions. Reply Box 590, c/o The Ohio State Medical Journal.

EMERGENCY ROOM PHYSICIAN — full or part time. High salary. Contract leading to partnership. Active, acute medical and traumatic service. No pediatrics. Ohio License required. Contact F. C. Witwer, M.D., Akron General Hospital, 400 Wabash Ave., Akron, Ohio 44307.

CINCINNATI—New office opening this year in Finneytown area, plan your space now. Contact: C. H. Schapera, M.D. 931-5555.

A BIT TIRED OF SMOG? Concerned about your family's future? Why not try a rural east-central Ohio community with clean air, clear water and a good school system? Modern medical office space available with two good hospitals within 15 minutes driving. Less than two hours to Columbus, Cleveland and Pittsburgh, in center of superb Muskingum recreational area. Retired physician will verify area's potential. Contact Area 614, 269-3187.

URGENTLY NEEDED: General Surgeon, Board certified or qualified, experience in Orthopedic, GYN, and Trauma is desirable. Modern 32 bed hospital located in rural north central Ohio with drawing area of 10,000-12,000. Excellent schools, economically stable community. Equipped office available for immediate occupancy. Excellent opportunity exists for an additional Family Physician. Reply to Box 611 c/o Ohio State Medical Journal.

WANTED: Physician to head up medical department for large automobile manufacturing plant in N.C. Ohio with approximately 3500 employees. Full time position with best employee benefits, including a new car provided. Reply Box 612 c/o The Ohio State Medical Journal.

An Equal Opportunity Employer

PSYCHIATRIC RESIDENCY — modern 120 bed hospital in Akron suburb, 40 mins. from Cleveland; comprehensive 3 yr. approved program. Area growing; high demand for psychiatrists. M. Menassa, MD., DME, Fallsview Mental Health Center, Cuyahoga Falls, Ohio 44222 (216) 929-8301.

— More Classified Ads on Next Page —

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HEALTH COMMISSIONER: Greene County, Southwest Ohio, well established county unit, population 135,000, (located near Dayton, Cincinnati, Columbus.) Competent staff of 45. Programs include diversified clinics, Home Care, Environmental Health. Requirements: M.D. with Ohio Licensure, Public Health Training and/or experience preferred. Salary open — $22,000 plus, and fringe benefits. Write or phone Dr. Robert Englefield, President, Board of Health, 120 Miami Dr., Yellow Springs, Ohio 45387 — phone — 513-767-7991.

GP WANTED in Lakeside-Marblehead area in the heart of Ohio's Lake Erie Vacationland. More than 4,000 residents, many more May through October. Excellent modern 132-bed hospital within 10 miles. A scenic area with boating, fishing, hunting, golf and other recreation. Write: Peninsula Chamber of Commerce, att'n C. H. Wolfe, P. O. Box 268, Marblehead, Ohio 43440.

RESIDENCY P.M. & R.: Newly approved Physical Medicine & Rehabilitation residency in 1500 bed University of Cincinnati Medical Center. Training includes P.M. & R. bed service, clinics, consultations, and EMG under four full-time physiatrists. Emphasis on comprehensive patient care. Individual training programs may start at anytime. For further information contact: Robert H. Jebsen, M.D., Professor & Director, Department of Physical Medicine & Rehabilitation, University of Cincinnati Medical Center, Cincinnati General Hospital, 234 Goodman Street, S2-15, Cincinnati, Ohio 45229.

RETIRED RADIOLOGIST has building equipment for sale. Located at 328 E. State St., Columbus, Ohio across from Grant Hospital. Suitable for Radiologist, Internist or Orthopedist. Contact Dr. W. H. Miller, 328 E. State St., Columbus (614) 221-3743.

IMMEDIATE OPENING in Student Health Service at large university in this state. Regular hours. Excellent fringe benefits. No night call. Reply Box 613 Ohio State Medical Journal.

PSYCHIATRIC RESIDENCES: We offer nothing but excellent psychiatric training in a stimulating, well-organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, three year program: $11,359; $11,922; $12,925. Five year program: $12,945; $14,950; $17,393; $23,198; $24,409. NIMH-GP Stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

INTERNIST—wanted to locate in a small progressive community. New modern Medical building adjacent to hospital available. Contact: Administrator, Southern Lorain County Hospital, Dickson St., Wellington, Ohio 44090.

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CANTON, OHIO—Medical Office adjacent to New Belden Village Shopping Center and Lake Cable area. Prime office space with reasonable rent. Inquire: Ernest Pagonis, D.D.S., 5208 Fulton Dr. N.W., Canton, Ohio 44718. Telephone 499-7881.

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Take over active practice. Rent furnished office with records. No cash required. Will introduce. W. D. Paul, M.D., 2691 E. Main St., Columbus, Ohio, phone 614-235-4224.

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(Continued from Previous Page)

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INTERNIST AND PEDIATRICIAN WANTED— Group of two general surgeons and one obstetrician-gynecologist looking for board qualified or certified internist and pediatrician. We are creating a partnership of young well trained physicians in a mutual complimentary practice. Incorporation is in process with excellent fringe benefits. We are located in north central Wisconsin serving a community of approximately 25,000 with a summer population of 200,000. We have excellent recreational and educational facilities including college. Starting salary is $25,000 wth partnership after one year. Anyone interested write to Dr. I. E. Schiek Jr. c/o The Schiek Clinic, Rhinelander, Wisconsin 54501 or call collect 715-362-6160.

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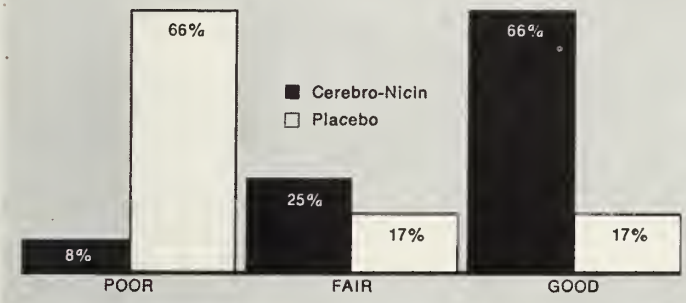
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CLEVELAND: 11955 Shaker Blvd., (216) 795-3200, A. C. Spath, Jr., R. A. Zimmermann
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
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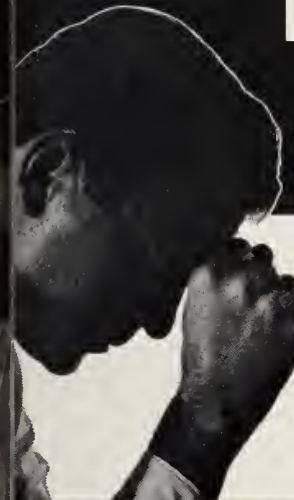
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T. Jakobovits
Fertility and Sterility, January 1970
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References: 1. **Montesano, P., and Evangelisle, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Vol. 66 • No. 9

The Ohio State MEDICAL JOURNAL

BLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

Tribute to Exhibitors



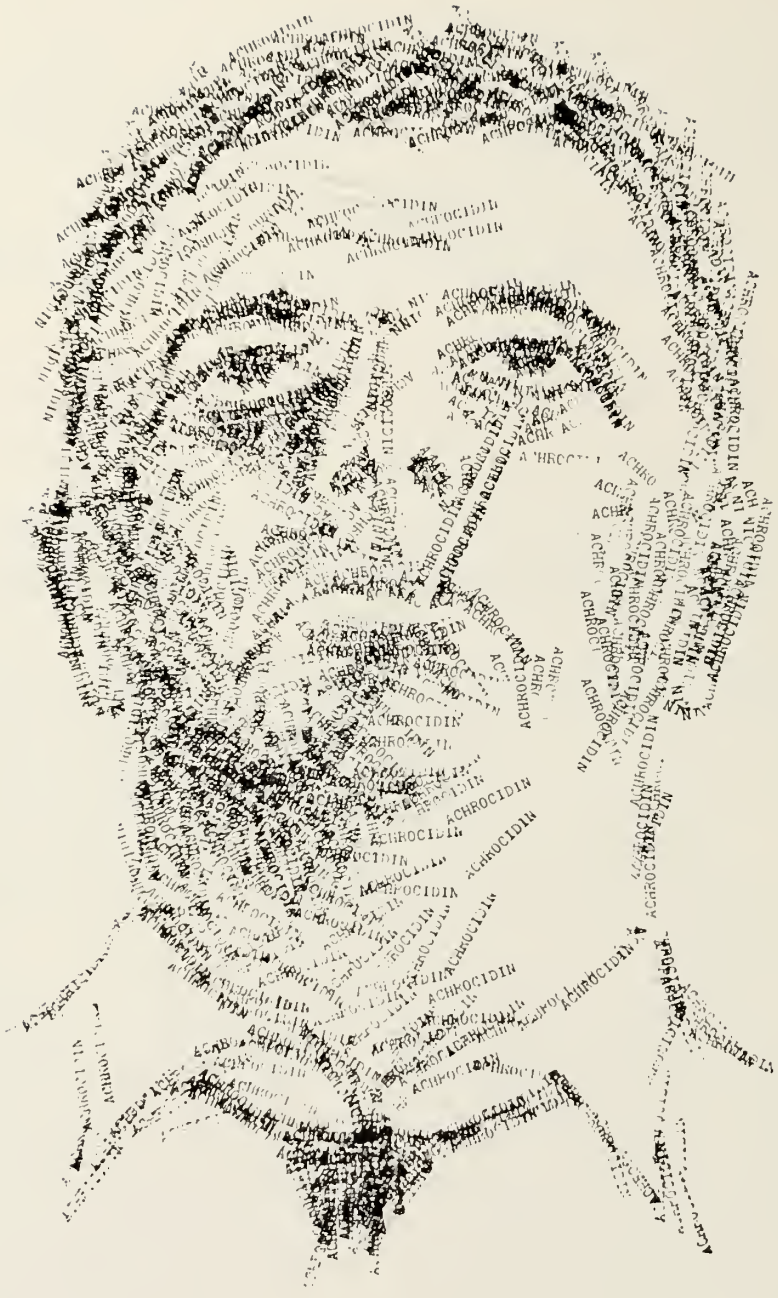
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Chasing the Knowledge Explosion—an Industrialist's Viewpoint — Page 868
The Practitioner's Interest in Laser Technology — Page 905
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Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

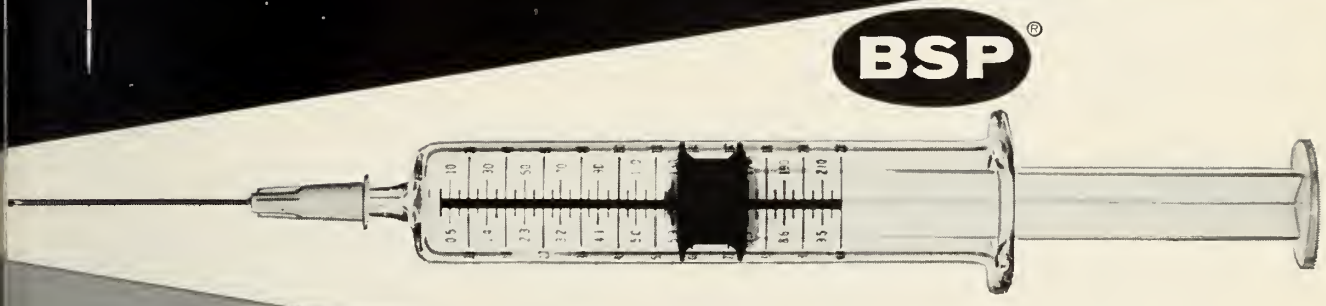
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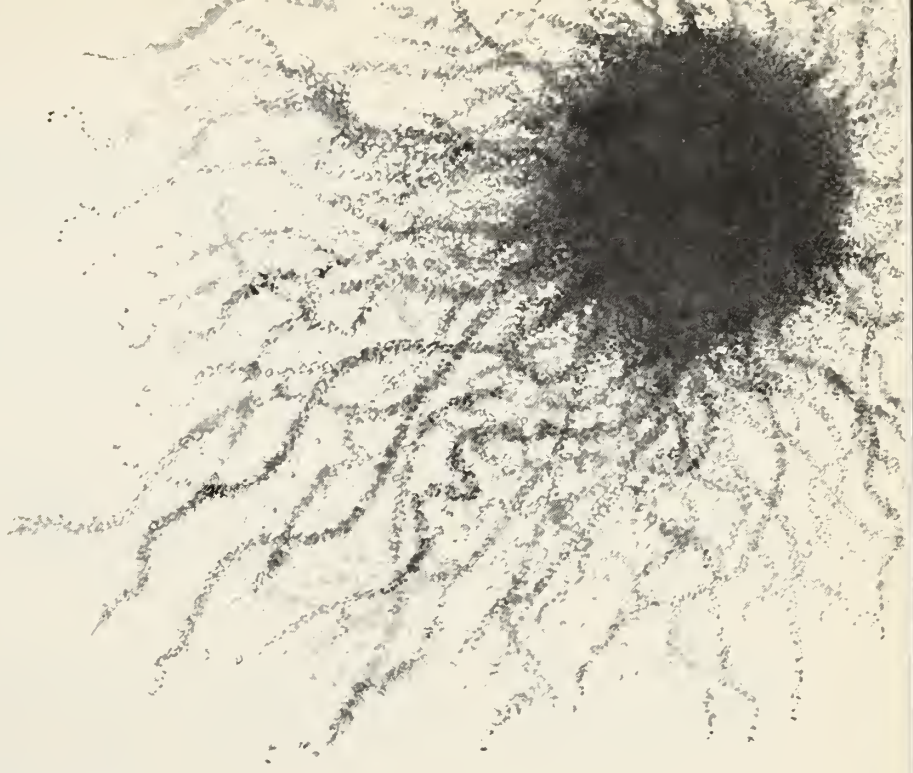
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Corticosteroid therapy week after week.

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and monilial overgrowth this week.

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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

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With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

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"Chasing the Knowledge Explosion"

By Thomas F. Wade, Dayton

Manager, Executive and Professional Placement
The National Cash Register Company

THESE NOTES emanate from a panel discussion held at the OSMA Annual Meeting in Columbus, May 14, 1970. The intent of the panel was to discuss the question of what the medical profession might do about the problem of professional obsolescence. The writer's task was to give some background as to how industry approached the problem of keeping or making its professionals technically sound.

The medical profession's part was taken by Dr. J. Judson Reamy, director of medical education, Ohio Academy of General Practice. Dr. Richard W. Juvancic, chairman, Section on Directors of Medical Education, was the moderator.

We would like to hope that the medical profession did not suffer from the same conditions relative to professional obsolescence that industry faced in the last decade or more. However, since the medical profession is made up of human beings, it is inevitable that there will be common problems.

The subtopic "How Did Industry Do It?" meaning what did industry do to combat obsolescence or keep its technical professional personnel up to date was perhaps more positive in its implied assumption than the writer felt it deserved. Being involved in placement problems and seeing the results of professional obsolescence it would be easy to reject the premise that "industry did it." However, second thoughts supported the idea—perhaps industry did not do everything it should have and perhaps some of the things it did and is still doing are wrong. In the main, though, large companies gave impetus to many programs to maintain a competitive edge of knowledge and to effectively pursue established objectives.

". . . it took foresight in areas of low visibility . . ."

On the part of management it took foresight in areas of low visibility. Technology was moving so rapidly that choosing and following the right one became a problem of significant importance.

It took an acceptance of high risk. Modern research and modern technology requires vast sums of investment with potentially high return but similarly high loss.

It took a decisiveness to accept certain directions of business and reject others that to some would be comfortable or "popular."

It took an action oriented management, and for discussion there seems to be two broad categories of action that industry pursued.

First, there is the extrinsic or visible programs that most companies established or broadened. These were basically to encourage advanced or continuing education through different means. Some of the more common are the following.

Seminars, by a person of prestige, on topics of particular interest to the scientists and engineers of the company, on company time and open to all who could profit from the discussion.

Tuition reimbursement programs to minimize educational costs for the employee so that he would be more free to pursue higher education. And, as well as tuition being refunded, time from work would also be given if necessary so that class schedules could be met.

Employing professors from universities to work in the industrial organization during summer vacation and teach a course in their particular specialization or devise a course suited to a particular need of the company.

An on-going program of evening education (not necessarily at a professional technical level) is also another approach to the problem of keeping people prepared for the next higher levels of responsibility or new directions of a company.

Awarding fellowships.

Giving professional recognition to the man through a recognized title (Scientist, Fellow, Associate Engineer, etc.).

Assisting the person to belong to and be

This article is the transcript of an address given by Mr. Wade on May 14, 1970 as part of a panel discussion entitled "Chasing the Knowledge Explosion," sponsored by the OSMA Section on Directors of Medical Education and the Section on General Practice, as part of the OSMA Annual Meeting program in Columbus.

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active in professional societies relative to his interests or the company's interests.

> ". . . approaching the problem
> of the need for
> interdisciplinary communication . . ."

To assist such efforts, as an example, in recent years NCR (National Cash Register) along with other companies in the Dayton area took rather active roles in the establishment of two significant institutions. One of these was the combining of extension educational programs of two state universities so as to put them on a campus with appropriate facility. The result of this effort is what is now known as Wright State University with an enrollment approaching 7,000 and a full-fledged graduate school program. Another effort will soon be housed in a new facility under the organizational title of the Engineering and Science Institute of Dayton. This organization is made up of all professional engineering and science associations in the Dayton area. The purpose: to combine the efforts of groups with different but related disciplines for more effectively meeting the expanding technology educational requirements of the 70's and approaching the problem of the need for interdisciplinary communication. It may be noted that the Planning Committee for the Engineering and Science Institute of Dayton consists of a significant group of leaders from industry and the higher educational institutions in the Dayton area. It is chaired by Mr. Carl F. Rench, vice-president of Corporate Product Development for NCR.

One of the major objectives of the planning group is to attain coordination between various organizations and institutions so that duplication of effort in the area of continuing education is minimized and to also achieve a complementary balance between the theoretical and applied courses of study that will help a professional make more immediate use of his education and give him a fully rounded background for progress in his career. It may also be noted that at least in the schools we are familiar with in the Dayton area (engineering in particular) students are being made aware of the fact that within five years from graduation unless they do continue their education they will be obsolete.

The foregoing represent, for the most part, general, basic and long term programs. There are other more immediate devices available for the individual or group: cassette tapes that may be listened to in appropriate moments in the office, at home or in the car. Programmed learning techniques have been developed to make reading more efficient as a means of gaining new knowledge. Cartridge films and video tapes provide excellent means of bringing voice and picture to the professional in an inexpensive and easy-to-take manner.

> ". . . it took responsible management
> to recognize a need,
> assume a leadership role
> and invest time, money and facilities . . ."

The second broad category pursued by industry is the intrinsic or the built-in programs of (personnel) management to motivate professional development. These could be more important in that many of the supporting activities suggested in the foregoing may not be utilized without them.

As pointed out earlier, it took responsible management to recognize a need, assume a leadership role and invest time, money and facility. It also meant re-organizing to meet change and to give the attention that is necessary to develop the specializations that modern technology requires and mold them into the overall general professional core of the company.

On the part of the individual it required a willingness to accept the responsibility of "professional thinking." Many professionals in industry have been group oriented towards a company or a project and an emphasis had to be developed that would retain the responsibility of the individual professional to the company but make him, truly, an individual professional within his accepted field of work. Through programs of individual performance evaluation industry has been developing the ability to focus more on "professional accountability"—giving definition to expected levels of professional performance and requiring adherence to professional standards, all leading to advancement in terms of position and income.

> ". . . something as simple
> but as difficult
> as accepting
> the fact of change . . ."

It required concentrating on something as simple but as difficult as accepting the fact of "change." Developing a sensitivity to priorities became another objective of the manager of the professional; What will do the most? What need must be met? What will pay off?

Recognizing individual differences became more apparent as a "must" with the growth of professional organizations to sizes that tended to remove the person from the apparent forefront of the efforts of his company and, striving to place the professional in an effort where he could contribute the most so as to draw on his particular

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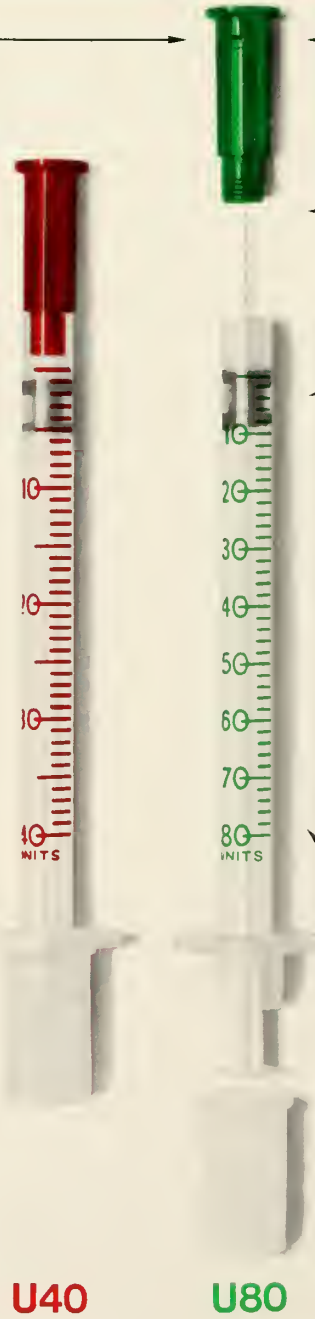
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talents, skill or genius followed. We all can't help in the same way.

Another basic principle that assisted in keeping attention on needs and directions is the practice of learning to work towards goals and objectives. Any lack of preparation becomes visible when an individual's personal evaluation is conducted in accordance with professional goals or objectives that have been stated and written down beforehand. It helps the person to relate himself more to the total effort of the company or the profession which he is serving.

More extensive planning made it mandatory to project what would be required and even though much of this would be considered "guess" it provides some framework that is more than "who knows?" Also involved within that is the opportunity to express what "should be"; again, not a guess but an educated assumption.

Everything starts with an individual thought or idea. To understand the basic problem of how to keep pace with changing technology there must be a recognition of reality. In the case of NCR we had to recognize that our traditional product line, degree of attention to research and development, marketing methods and virtually every function or area of our company had to change. The age of computer systems was coming close to our lifeblood. To maintain our competitive edge in the business systems field it was mandatory that new directions be taken. Everyone cannot be everything and therefore this very fact required change met with some degree of resistance on the part of those who were too far along in their careers or who did not have the personal flexibility to accept something new. As a company, however, the response came about and today, slightly more than 10 years past our entry into the computer systems field, we are a completely different company.

> **". . . he must discriminate between what he must know and what he would like to know . . ."**

Today NCR means computers as well as other types of business equipment. We are a leader in the computer systems industry. We had to seek the best utilization of talents and we had to change our concepts of what we think is "best" or "most". We had to sacrifice immediate profit for investment to gain higher profit. We had to organize for efficiency based upon changes in concept just as physicians may have to change their concepts of what is a "doctor" and what will be the major functions that he carries out as a professional.

Individuals employed or self-employed will have the problem of simplifying the complex information that is amassing and selecting that which is more promising for his objectives. He must know which to weed out and disregard. He must discriminate between what he must know and what he would like to know.

Another important function that industry is carrying out in this problem or in this effort to reduce the problem is that of assisting in career development, generating a professional attitude—not one that is "self"-oriented but one containing the precepts and recognized demands of the profession of which he is a part.

True, there are differences between industry and the medical profession. The individual physician has no direct supervision, it is easy for him to set himself apart from any controlling group or critical element of society. He must meet not only his own standards but also that ambiguous expectation of his clientele and the public. The doctor is a company within himself. He must organize accordingly.

> **". . . it is not a new problem but technological and social change is happening faster . . ."**

The problem of keeping pace with technological advance is not insurmountable; it is not a new problem but technological and social change is happening faster. Knowledgeable professionals have always attempted to maintain their position or expected skill. The much discussed "technology explosion" re-emphasizes "the need to learn" that is a responsibility of all who serve others; it forces support of unexplored facets of our life on Earth and in the universe in that it provides new tools to work with. It hastens new horizons, new concepts. It stimulates visions of an improved life.

Not all who are basically responsible for contribution to human welfare have the vision or motivation to take their full professional role in our total scheme. Those in leadership positions must devise the means to assist greater numbers of professionals to maintain or obtain a level of knowledge that permits participation in efforts concerned with the frontiers that surround us. Without the necessary knowledge the unprepared will diminish the productivity of our efforts.

The leadership of industry responded to "the need to learn" and although the motivation, in part, was to maintain profitability and growth the effort goes beyond immediate needs. It extends to communities and to nations and human resources in our natural environment.

What is worth doing..



In 1936 A. E. Smith, professional at Woolcombe, England, recorded the lowes golf score for an 18 hole course. He shot 55 and was 15 under par. The course at Woolcombe, which measured 4,248 yards was covered in 4, 2, 3, 4, 2, 4, 3, 4, 3 out and 2, 3, 3, 3, 3, 2, 5, 4, 1 in.

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Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.
Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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281-0

"Relationships Between Community Hospitals and Medical Schools"

By Howard S. Madigan, M.D.
Associate Dean for Continuing Education
Medical College of Ohio at Toledo

THERE IS INCREASING NEED for effective relationships between community hospitals and medical schools. Several factors contribute to this situation.

First, the well-established medical schools are undergoing significant change in relation to the communities and areas which they serve. Much of this change is a result of new elements which have been introduced into our health care system, for example, Medicare, Regional Medical Programs, Comprehensive Health Planning.

Coupled with these changes is the process of medical school curriculum revision, necessitated by recognition that, to a large extent, the traditional "two-year pre-clinical, two year clinical" format is no longer applicable to modern medical education. New medical schools, which are developing rapidly, are alert to both of the above factors, and are pursuing realistic, often innovative, plans for modern medical education, to help meet the health needs of society.

The Broadening Scope

In a variety of ways, community hospitals are changing emphasis and broadening their scope, in response to the challenges of a new health care system. For example, many are undergoing transition from the concept of a hospital solely for the care of the sick to that of a community health center concerned with prevention and detection of disease as well as diagnosis and treatment.

Graduate medical education increasingly is being recognized as a proper responsibility of medical schools. Community hospitals with physicians involved in clinical teaching are essential to effectiveness of medical schools in this phase of medical education.

As a corollary, Residency Review Committees of the American Medical Association Council on Medical Education are giving greater attention to the matter of an effective affiliation between hospitals and medical schools in their evaluation of programs. Hopefully, affiliation with a medical school will not become a *sine qua non* for Residency Program approval. This could result in ineffective linkages between hospitals and medical schools, with survival of the Residency as the primary objective. However, there are and will be many opportunities for community hospitals to establish functional educational relationships with the medical schools in their areas. These can lead to effective, high quality undergraduate, graduate, and continuing education, thereby enhancing the ability to provide improved health care for people.

Planning the Relationship

The present purpose is to set forth some observations and guidelines regarding the establishment of community hospital medical school relationships, based largely on a recent personal experience. Although it is recognized that a wide variety of circumstances affect such relationships, some basic concepts and principles may possibly be useful in modifying, expanding, or improving existing affiliations; or they can serve to guide the development of recent and new associations of community hospitals and medical schools.

Planning the relationship is an essential first step. Key factors to be considered in this planning are:

The **size, character** and **attitudes of the community.** There are significant differences to be anticipated if the situation involves a moderate-sized community with one or two hospitals, in contrast to a larger, metropolitan area with several hospitals and perhaps more than one medical school. Community attitudes toward educational institutions, hospitals and the medical community are imporant considerations;

Secondly, the **available hospital facilities,** which should be classified as to their existing educational resources as well as their potential for development. Included in the term "resources" are physical facilities, personnel, funds. Consideration should also be given to resources for non-physician education and training, for example, nurses, technologists, therapists.

Defining Objectives

The **philosophy and attitudes of hospital trustees, administration and medical staff,** with respect to **involvement** in undergraduate, graduate and

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.



Indications. For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications. History of sensitivity to meprobamate.

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient, if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

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I'll scream if I don't get away!

continuing education must be determined. One needs to know their **motivation** for developing an affiliation, e.g., to acquire house staff, to improve patient care, to provide learning opportunities. The **objectives** of the affiliation must be defined. There should be a clear understanding of anticipated benefits to the hospital **and** what the hospital expects to contribute to the medical school; and this not limited to finances. This aspect may become more complex when more than one hospital in a community has the potential for affiliation. Traditional relationships among the hospitals interposes a factor which must be considered in planning medical school affiliations.

The **philosophy and attitudes of the medical school administration and faculty** with respect to their involvement in educational activities in the community hospital must be ascertained. Of primary concern here is the degree of responsibility toward graduate and continuing education defined by the medical school administration. Faculty members generally recognize their role in graduate education in the university hospital, and increasingly are becoming involved in continuing education in the medical center.

However, interest in and enthusiasm for involvement in these phases of medical education outside the medical center, that is, in community hospitals, varies in both quantity and quality. The advent of Regional Medical Programs, Comprehensive Health Planning, and similar "community-oriented" programs which involve medical education has been an effective change agent which has forced the academic community to examine its role in the community and to participate in community health affairs.

Good planning requires that those who are to be involved in the program participate in its development. Unilateral planning must be avoided.

Planning should also include provision for regular review of each program to detect areas where an expected level of effectiveness has not been achieved; and to develop mechanisms to strengthen such areas.

The Toledo Experience

To illustrate, I cite a personal experience in helping to establish an effective relationship between St. Vincent Hospital and Medical Center, and the new Medical College of Ohio at Toledo, which has been accomplished during the past three years.

First, what are the factors which exerted a positive influence on planning the relationship?

(1) The existence of a 600-bed, community



hospital with a modern physical plant and first-rate equipment;

(2) A progressive administration with real community interest;

(3) A medical staff of high quality, with a high proportion of board-certified and board-qualified members, possessing interest and ability in clinical teaching;

(4) Long experience with intern and resident education;

(5) A full-time director of medical education, whose responsibilities and objectives were clearly understood by the Medical Staff and Administration;

(6) The decision to locate the medical school in Toledo, which had received strong and active support from the medical community and others;

(7) The Medical College president was imbued with the philosophy that the Medical College must relate to and serve the medical community and the community-at-large (in this instance the 20-county area of Northwestern Ohio).

The **objective:** to establish a sound, effective relationship between St. Vincent and the Medical College of Ohio at Toledo for purposes of graduate, continuing and undergraduate education.

Planning Process

In the **planning process,** the primary, essential step was to **establish and maintain communication.** To accomplish this, introductory, exploratory, conferences were held, involving the St. Vincent Medical Staff Executive Committee, the director of medical education, administration and the MCOT president. At these conferences, general philosophies and broad objectives were set forth and discussed. These meetings proved to be very informative, for all concerned.

The initial MCOT clinical faculty appointment was that of Clinical Associate Professor of Surgery for the director of medical education at St. Vincent. The primary purpose of this appointment was to provide for and facilitate **liaison** between the Hospital and the Medical College during this planning phase.

An advantage accrues when a new medical school and a community hospital begin to plan the relationship early in the course of development of the school. Then, there is opportunity to have a better understanding of objectives and how they may be achieved through cooperative effort.

Next, **definition of mutual objectives** in the areas of graduate and continuing education was undertaken. In terms of graduate education, continuation and improvement of residency programs at St. Vincent and the projected need to develop strong residency programs for the Medical College of Ohio at Toledo, were primary considerations. The concept of combined hospital residency programs had been implemented for obstetrics-gynecology prior to the establishment of MCOT, involving three hospitals. Thus, to help achieve the objectives of the Medical College and of St. Vincent, a surgical residency program was developed which would utilize the combined facilities of St. Vincent and Maumee Valley Hospitals and be identified with MCOT as "MCOT and Associated Hospitals Surgical Residency."

Similar plans evolved for the residencies in obstetrics and gynecology, pediatrics, internal medicine, and orthopedics. In addition to Maumee Valley Hospital, which is presently the **primary** teaching hospital for MCOT, three hospitals in the community have become involved, to varying extent, as "associated hospitals" (St. Vincent Hospital and Medical Center, the Toledo Hospital, and Mercy Hospital).

In each instance, emphasis has been placed on two factors: What can the hospital contribute to the specific residency program? What can MCOT participation contribute to the hospital program? An effort is made to make optimum utilization of the resources of each hospital and of MCOT. Plans are underway which ultimately will establish almost all residency programs as "MCOT and Associated Hospitals".

For a number of reasons, internship programs at the several hospitals have not been combined. However, the Associated Hospitals are giving thought to the plans for residency programs when requesting approval for changes in intern programs and number of positions to be offered.

To this stage, mid-1969, agreement regarding these Residency programs was **informal,** that is, no written agreements were formalized.

Continuing Education

In the area of continuing education, the objectives of St. Vincent were embodied in participation, with other local hospitals, in the Northwestern Ohio Institute for Continuing Medical Education. NWOICME was initiated in 1966 by the several directors of medical education in Toledo and subsequently, expanded through reorganization of the Post-Graduate Education Committee of the Academy of Medicine of Toledo and Lucas County. The scope of NWOICME now extends to the 20-county area of Northwestern Ohio, an area which coincides with the Northwestern Ohio Regional Medical Program.

From its inception, MCOT recognized a responsibility for continuing education. President Glidden Brooks frequently expressed and empha-

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See Clinical Considerations section on last page...

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Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated dividuals with a history of hypersensitivity or toxic reacti gentamicin.

Warnings: Patients receiving treatment with GARAMYC should be under close clinical observation because of the to ity associated with the use of this drug. Ototoxicity, vestibu and auditory, can occur in patients, primarily those with p existing renal damage, treated with GARAMYCIN Injectal usually for longer periods or with higher doses than rec mended.

GARAMYCIN Injectable is potentially nephrotoxic, and t should be kept in mind when it is used in patients with p existing renal impairment. Kidney function diminished infection of the upper urinary tract may, however, impr during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs su as streptomycin and kanamycin or of potentially nephroto drugs such as polymyxin, colistin, and kanamycin with gen micin sulfate has not been shown to afford any clini advantages and, moreover may result in additive toxici Monitoring of vestibular, cochlear, and renal function w provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in v serious infection develops, serum concentrations of the drug rise, with consequently increased risk of ototoxicity. In thes tients or in those in whom recommended dosage or duratio therapy must be exceeded as a life-saving measure, routine st of kidney function should be performed when possible. These be supplemented by evaluation of the vestibular and auditory tion and measurement of serum concentration of the drug feasible. Serum concentrations of gentamicin should be maint below the range of 10-12 mcg./ml. to reduce risk of ototoxicit

Ordinarily, treatment should not be given for more than 7 days or be repeated unless required for serious infection no sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injec may occasionally result in overgrowth of nonsensitive organism superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxici nephrotoxicity have not been established. Studies in pregnant mals have not revealed teratogenic or ototoxic effects in the GARAMYCIN Injectable should not be used in pregnant patien in women of childbearing age unless its use is deemed advi by the physician.

Adverse Reactions: The overall incidence of ototoxicity consid related to treatment with GARAMYCIN Injectable was 2.8 per (16 of 565 patients). Contributory factors (two or more factors relevant to most patients) were as follows: 10 had azotemi received a total of 1 gram or more of the drug, 7 had recentl ceived other potentially ototoxic antibiotics (streptomycin or k mycin), and 5 were over 60 years of age. Six also had decre high-tone hearing acuity, which returned to or toward norm the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients sh increases in BUN that were probably related to treatment GARAMYCIN Injectable. Of 20 increases probably or possibly re to treatment, 7 were reversible, 9 occurred in terminal patients, 4 had no follow-up.

Other adverse reactions associated with treatment were one inst each of urticaria, decreased hematocrit, and reversible depre of granulocytes with normal bone marrow. Other rarely repo and possibly treatment-related adverse reactions were anemia creased reticulocyte count, rash, purpura, drug fever, hypoten convulsions, twitching, salivation, nausea, vomiting, increased t aminase activity (SGOT or SGPT), increased serum bilirubin creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple- vials, for intramuscular administration.

For more complete prescribing details, consult package inse Physicians' Desk Reference. Schering literature is also avail from your Schering Representative or Medical Services Departm Schering Corporation, Union, New Jersey 07083.

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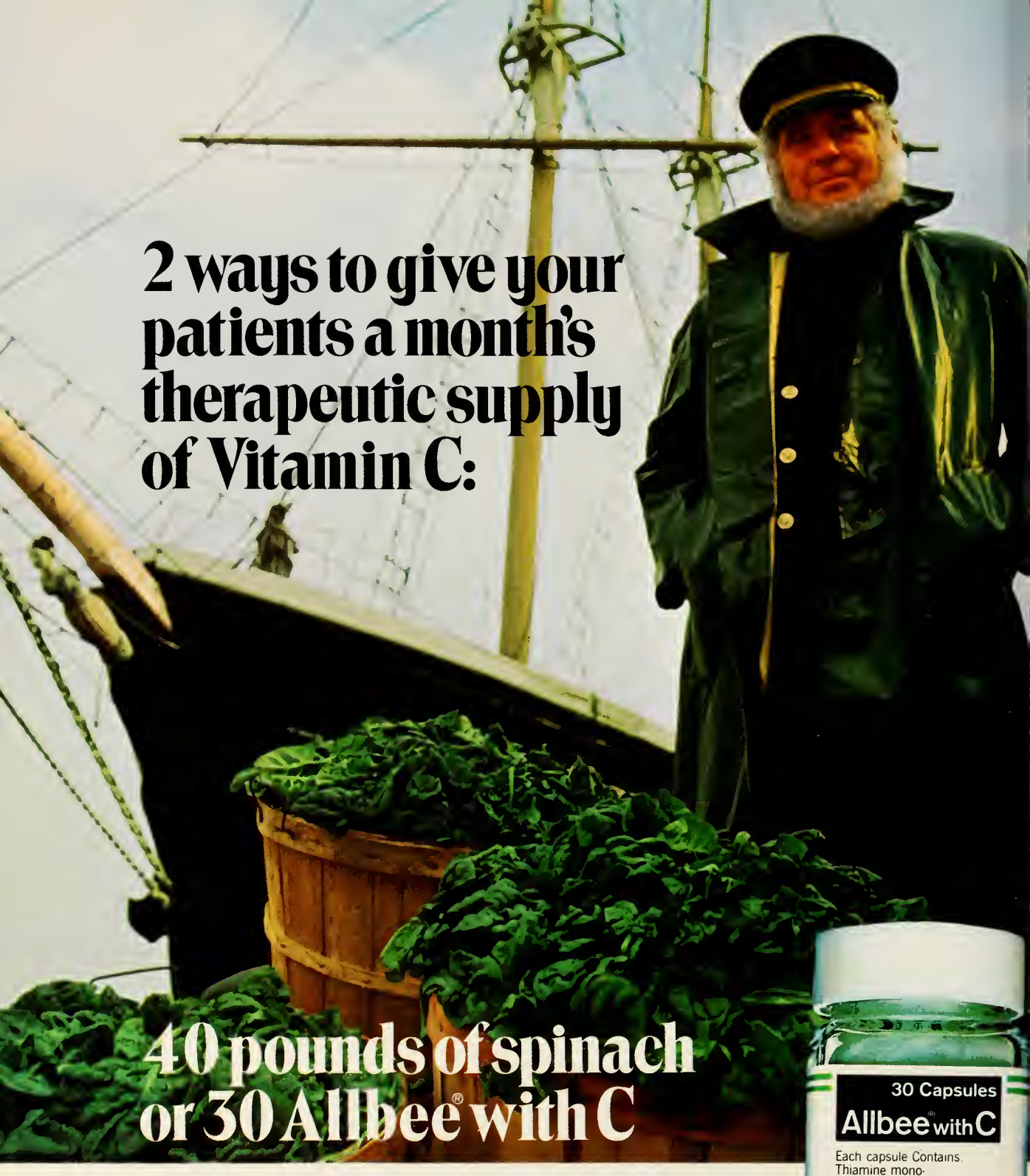
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phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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Although raw spinach is an excellent source of vitamin C, your patient would have to eat 40 pounds a month (about 1⅓ lbs. a day) to get as much ascorbic acid as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). If the spinach is cooked, a person would have to ingest more than twice as much because cooking destroys much of the vitamin C, and still more is lost when the liquid is drained off. Allbee with C also contains therapeutic amounts of B-complex vitamins. This handy bottle of 30 capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

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A·H·ROBINS

sized the necessity for the Medical College to be active in continuing education. To this end, an Assistant Dean for Continuing Education was appointed almost a year in advance of the opening of the School.

Again, objectives coincided and cooperative planning proceeded. Many doctors in Toledo who were active in continuing education on the staffs of local hospitals were appointed clinical associates on the faculty of MCOT. They also became participants in undergraduate curriculum planning and teaching.

Leading Up to Agreement

An essential element of these early plans and cooperative activity was **flexibility.** Thus, early on, no formal, written agreements were made, although it was recognized that this would be desirable when program development achieved some degree of stability.

Consensus as to organization, administration and operation of residency programs has now been formalized in a written Agreement, entered into on January 15, 1970, by MCOT and Associated Hospitals, for residency programs in obstetrics-gynecology, surgery, pediatrics, orthopedics, and medicine involving Maumee Valley Hospital, St. Vincent, Toledo and Mercy Hospitals. Others may be involved in the future.

If a medical school-community hospital relationship is **properly planned,** the next step is to **implement** the relationship **in accordance with the plans,** that is, both groups must do what they have agreed to do; assume appropriate responsibilities and exercise proper authority, as **agreed.** Lack of communication, failure to assume responsibilities or improper exercise of authority, are factors which can readily disrupt the relationship.

The appointment of an Assistant or Associate Dean for Continuing Education or someone to assume that responsibility can help to promote and establish relationships with the medical community which the school serves, including the community hospitals. The medical school is then more likely to be viewed as a partner, rather than as a threatening force. A **commitment** of this sort, however, is not sufficient. There must be **involvement** by the medical school faculty and by the hospitals, if the relationship is to be effective in achieving better medical education and thereby improved patient care.

Community hospitals can and should be involved in medical education. It is essential to recognize that this will succeed only when a significant number of physicians are interested and willing to give considerable amount of time and effort to the cause. The effectiveness of any given program will be directly proportional to the interest, motivation and commitment of the medical staffs of the hospitals involved.

The changes in our society, changes in health care delivery and in medical education, dictate changing relationships between community hospitals and medical schools. To adapt to these changes and insure continued progress in medical education requires a relationship based on mutual respect and trust, good communication, sound planning, cooperative implementation, and work.



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NONE OF ITS DISADVANTAGES

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Full 7½ gr. Tablet
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References on request

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ALL OF ITS ADVANTAGES

insures full sedative action

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Chloral — the "old reliable" — for more than 100 years is dramatically improved in DriClor (chloral hydrate with the amino acid glycene). DriClor is less toxic . . . more stable . . . non-irritating to the stomach . . . and more effective grain for grain.

The effective sedative, hypnotic and anti-convulsant form of Chloral Hydrate.

Also Chlorasec for quick, even sleep. DriClor inner core (equivalent to 3.75 Grs. of Chloral Hydrate). Secobarbital acid outer coat (.75 Grs.)

Restrictions On Certain Dangerous Drugs

Following is the text of a newsletter of the State Board of Pharmacy of Ohio dated July 14, 1970.

Use of Methadone in Maintenance Treatment of Narcotic Addicts

The Department of Justice Bureau of Narcotics and Dangerous Drugs and HEW's Food and Drug Administration have jointly announced new regulations governing the distribution and use of Methadone in community Drug Addict Rehabilitation Programs to become effective July 11, 1970.

The new regulations require **advance approval** of Methadone Rehabilitation Projects from both agencies although applications to engage in these projects need only be submitted to the FDA. Information and forms for filing such application may be obtained from the U.S. Food and Drug Administration, 5000 Fisher's Lane, Rockville, Md. 20852.

Now that an acceptable protocol for Methadone Maintenance Programs has been established, Ohio Pharmacists are reminded that any use of this drug other than under these regulations or in the course of legitimate medical practice is illegal and a violation of federal laws. Specifically, a physician may not prescribe or use Methadone nor may a pharmacist dispense the drug to maintain a narcotic addiction **unless it is done under these amendments** of Section 411, Part 151, Title 26 BNDD and Part 130, Title 21 FDA regulations.

Meprobamate Becomes DACA (Drug Abuse Control Act) Drug July 6

Accordingly, an inventory of Meprobamate stocks is immediately required and all records of inventory, purchases, dispensing, and administration, must be kept for three years. Authorized prescription refills will have the usual limit of not more than five, and for a period not longer than six months.

Any Meprobamate combinations equal or lesser in controlled substance content to Milprem 200 and 400, Milpath 200 and 400. Equinitrate 10 and 20, PMB 200 and 400, Pathibamate 200 and 400, Miltrate 10 and 20 are exempt from these new controls.

Unlicensed Dangerous Drug Distributors

Several recent incidents where pharmaceutical salesmen have offered special private deals on Dangerous Drugs to Pharmacists occasion this reminder of responsibility under Ohio Law.

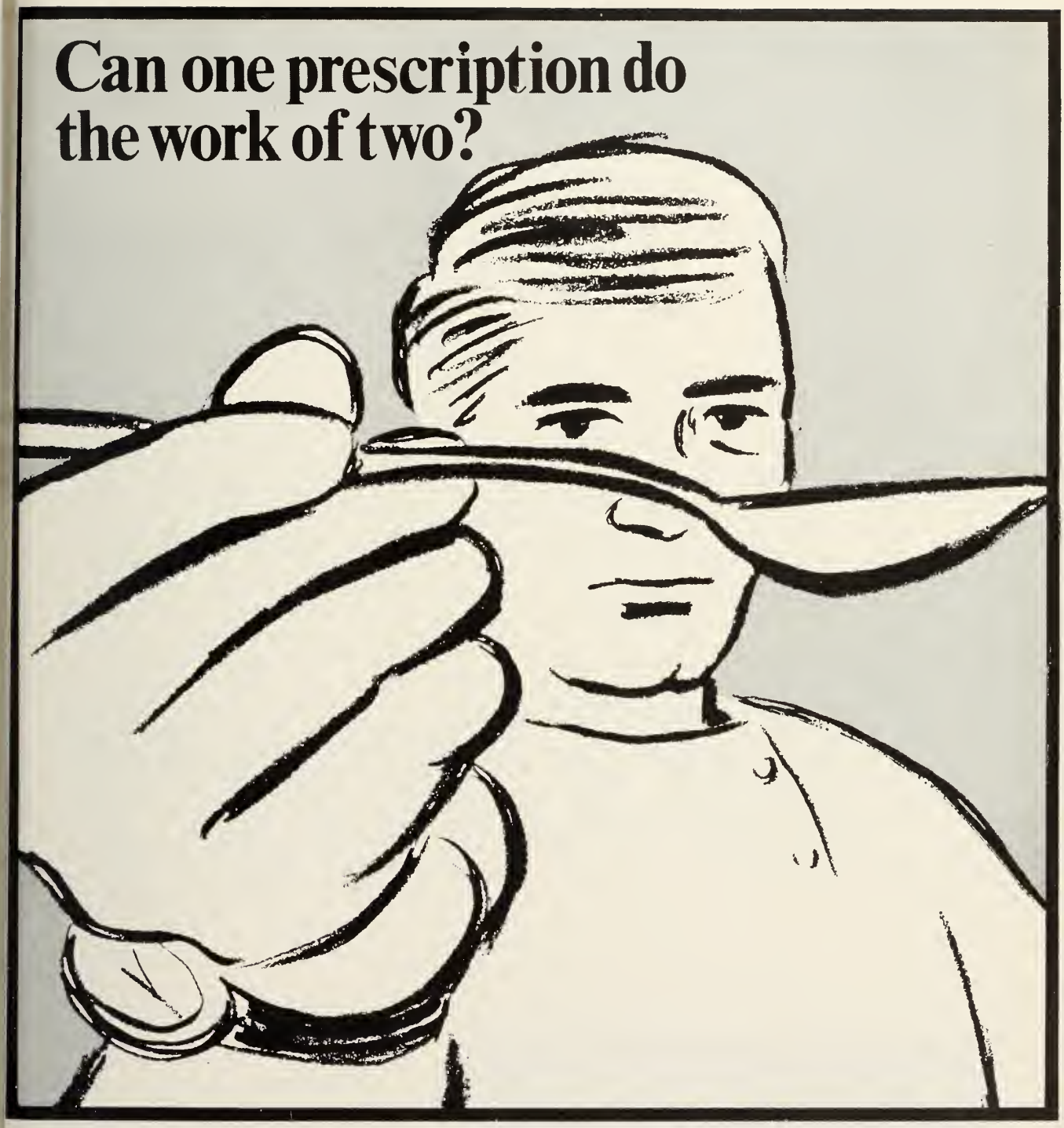
Terminal Dangerous Drug Distributors may only purchase Dangerous Drugs from registered Wholesalers or Manufacturers. Pharmaceutical salesmen are not registered individually and have no legal right to possess or distribute Dangerous Drugs other than those authorized by their company, such as drug samples.

If a Terminal Distributor buys a large quantity of a Dangerous Drug and proposes to share a part of it with another Terminal Distributor, he must have registration as a Wholesale Distributor. Salesmen have no right to help him "peddle" these drugs to their other customers by carrying them around in their cars.

Aside from the fact that this procedure is absolutely forbidden by all the pharmaceutical manufacturers with whom we are familiar, the Terminal Distributor making a purchase under these circumstances is in violation of the Ohio Dangerous Drug Law.

During the month of June, inspections were made in 172 pharmacies, 55 hospitals, 44 industrial first aid rooms, 37 wholesalers, 15 nursing homes, 9 doctors offices, and 15 special investigations were made in the following: Akron, Ashland, Barberton, Bellsville, Blanchester, Boardman, Bridgetown, Calcutta, Campbell, Canfield, Canton, Centerville, Cincinnati, Cleveland, Columbiana, Columbus, Cornersburg, Cortland, Day Heights, Dayton, Delaware, East Liverpool, East Palestine, Findlay, Lexington, Leetonia, Lisbon, Loveland, Lucasville, Georgetown, Girard, Greentown, Harrison, Howland, Kenton, Kettering, Mack, Mansfield, Massillon, Milford, Mt. Carmel, Mt. Orab, Navarre, Perrysburg, Petersburg, Powell, Ripley, Sabina, Salem, Salinesville, Silverton, Springfield, Uniontown, Vienna, Wellsville, Wilmington, and Youngstown.

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

The Wm. S. Merrell Company
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

0-2102 (1832)



MEDIAN FAMILY INCOME AND PHYSICIANS' FEES BOTH UP 9.3% IN 1969

Median family income rose in 1969 from $8,632 to $9,433, or an increase of 9.3 percent, according to a recent release of the Census Bureau of the Department of Commerce.

Physicians fees, according to the Consumer Price Index of the Bureau of Labor Statistics, increased from an index number of 149.7 to 160.0, or 9.3 percent during the same period.

EDITOR'S NOTE: *This is one of a series of articles, the purpose of which is to inform the membership of pertinent facts about health care. The content will be intentionally brief and will present only a few significant facts in each issue. We trust that readers can thus more easily remember such information and use it as appropriate in discussions with patients and others. "Capsules" are prepared by OSMA Director of Economic Research, Charles F. Price. If you need explanation or elaboration on any of the data, please direct your requests to him at the OSMA office.*

The Arizona Heart Association has scheduled its 14th Annual Cardiac Symposium to be held at the Arizona Biltmore Hotel, Phoenix, January 22-24, 1971. For information, write Arizona Heart Association, 1720 E. McDowell Road, Phoenix, Arizona, 85006.

Convocation on Medicine and Theology Scheduled in Cincinnati

"Rx for Mr. Whole Man" is the theme of a Convocation on Medicine and Theology to be held at the Netherland Hilton Hotel in downtown Cincinnati, Thursday, October 29, beginning at 9:00 a.m.

Sponsoring organization is the Board of Health and Welfare Ministries of the West Ohio Conference for Clergy and Physicians. The workshop is planned to help (1) bring together physicians and clergymen; (2) encourage dialogue between medicine and the clergy; and (3) discuss some of the important ethical decisions that face both groups.

Guest speakers will include the following:

Francis J. Braceland, M.D., senior consultant and chairman of Development and Planning, Institute of Living, Hartford, Conn., lecturer in psychiatry and editor of the *American Journal of Psychiatry.*

Paul C. Jenks, M.D., general practitioner in New York State, secretary and past president of the Seneca County (N.Y.) Medical Society; associated with the Taylor-Brown Center, Waterloo, and outstanding lay church worker.

James Edward Doty, Ph.D., D.D., president, Baker University, Baldwin City, Kansas; outstanding clergyman, writer and television panelist.

The Rev. Robert M. Collie, Th.D., director, Program in Pastoral Care and Counseling, West Ohio Annual Conference of the United Methodist Church.

Physicians and clergymen are invited; registration fee, $5; attendance limited to 250; register with the Rev. Bruce McClure, Bethesda Hospital, Oak and Reading Road, Cincinnati 45219.



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A hospital for the treatment of Psychiatric Disorders

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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association

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began under the sponsorship
of the Ohio State
Medical Association.

Today, over 3 million Ohioans
are served by Blue Shield.

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3770 N. High Street
Columbus, Ohio 43214



With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

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WALKER, CORP & CO., INC.
Syracuse, New York 13201

Fiscal Agent Reports on Medicare Payments for This Area

Nationwide Mutual Insurance Company processed 1.4 million Medicare claims and paid $75.7 million in Medicare benefits during the federal health plan's fourth year of operation, ending June 30. Nationwide Mutual is fiscal administrator for much of the government's Medicare programs in Ohio and West Virginia.

The company's Medicare claims volume and payments, respectively, were 7.2 percent and 9 percent higher than those of the previous fiscal year. However, rates of increase were well below hikes of 12 percent in claims and 27 percent in payments recorded during 1968-69.

The declining rates of increase were attributed in part to a stabilization in Medicare use. Edwin M. Erickson, vice-president in charge of Nationwide's Medicare operation, said, "There always seems to be a surge of claims as any new program begins, after which volume drops to a more normal level.

"Medicare will serve more people annually as more people reach 65th birthdays and enter the program, while the skills of physicians and other providers of health-care facilities help the average American to live longer."

Erickson said, "The Social Security Administration has been energetically applying medical cost controls, and physicians and other providers in Ohio and West Virginia have cooperated in holding the line on medical service costs in the past year."

Medical benefits paid to Medicare beneficiaries are based on the customary fees charged by physicians for like services to all patients, Erickson explained, and do not exceed the prevailing fee charged by most physicians in the area.

Reimbursements to hospitals, extended care facilities, and home health agencies are based on their reasonable costs, he continued.

Nationwide Mutual administers Medicare's Part B program for more than 800,000 beneficiaries in all but five (Ashtabula, Cuyahoga, Geauga, Lake, and Lorain) of Ohio's 88 counties and for almost 200,000 in West Virginia.

The Part B portion of Medicare pays for physicians' and many related medical services. It is an optional coverage for which beneficiaries pay $5.30 monthly, a sum that is matched by the federal government.

In the past year, Nationwide processed 1,320,000 Part B claims and made Part B payments of $57.7 million. Ohioans filed 1,058,000 of these claims and received $49.1 million. West Virginians received $8.6 million for 262,000 claims.

Nationwide Mutual also processed some 78,000 Part A Medicare bills during the past year

and paid over $18 million in benefits. Part A coverage helps pay for hospital care and related health services, when necessary, in extended care facilities or at home following hospitalization. Nationwide has been selected as fiscal agent for Part A service by 114 health care providers in Ohio.

Association of Blood Banks to Meet on West Coast

Advances in tissue matching and other phases of human organ transplantation will be the subject of a seminar and several papers at the 23rd annual meeting of the American Association of Blood Banks October 27-30 at the San Francisco Hilton. Immediately preceding the meeting, October 26, the Association will conduct two simultaneous technical workshops: a laboratory workshop entitled "Quality Control in Blood Banking" and a seminar workshop, "Problems Related to Transfusion."

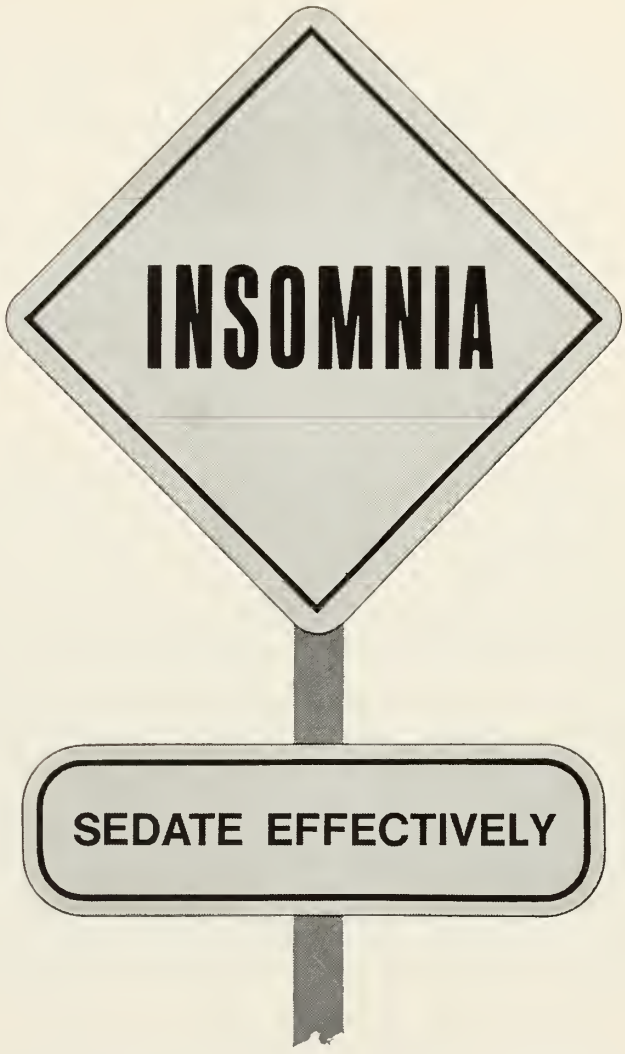
For details, write American Association of Blood Banks, 30 N. Michigan Ave., Suite 1322, Chicago, Illinois 60602.

Breakthrough Announced in Alcohol Dependence Treatment

A new tranquilizer for the treatment of alcohol dependence, Serentil (mesoridazine), has been developed and made available by Sandoz Pharmaceuticals, Hanover, N.J. The new agent offers specific advantages in addition to relief of the anxiety, tension and depression that may precipitate alcohol abuse: these include antiemetic properties, an apparent lack of habituating characteristics or hepatic toxicity, and the availability of both oral and parenteral forms.

In preparation for release of Serentil, Sandoz supported the Center of Alcohol Studies, Rutgers University, in a massive statistical survey of alcohol dependence and physician's attitudes toward the problem, including a state-by-state analysis. From the survey and other data it was shown, for example, that **while Ohio ranks fifth in the total number of alcoholics, it ranks 13th in per capita number.** It was also noted that more Ohio physicians (compared with the national average) report that at least half their problem drinkers are women.

As part of its program to introduce Serentil, Sandoz is offering interested physicians a series of recorded panel discussions with leading authorities on alcohol dependence and its treatment. Also in preparation by Sandoz is an *Alcoholic Directory*, a state-by-state reference of treatment facilities and other pertinent data.



With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

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WALKER, CORP & CO., INC.
Syracuse, New York 13201

painless intramuscular therapy for calcium deficiencies:

Calphosan®

calcium glycerophosphate, calcium lactate

To bring effective calcium therapy to the patient, Calphosan may be administered intramuscularly . . . without pain, inflammatory reactions, induration or sloughing. Injections twice weekly for a series of 5 to 10 injections are recommended.

Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

Write for free copy of "Calcium: The Ubiquitous and Essential Element" and for samples.

THE CARLTON CORP

Tenafly, New Jersey 07670



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during July. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

DELAWARE
Judith Kidd Held
Delaware

CUYAHOGA
Felino V. Barnes
Cleveland
Wilfrid M. Gill, Jr.
Cleveland
Luis G. Maldonado
Cleveland
Edith R. Papa,
Cleveland
Ahmed B. Papa
Cleveland
John G. Pasalis
Cleveland

FRANKLIN
Joseph R. Anthony
Columbus
Robert C. C. Chiu
Columbus
John E. Hastings
Columbus
Charles V. Mattingly
Columbus

HAMILTON
William J. Avery
Cincinnati
Richard L. Cowen
Cincinnati
C. Lawrence Decker
Cincinnati
Charles H. Deitschel, Jr.
Cincinnati
William H. Gates
Cincinnati
Ibrahim H. N. Habiby
Cincinnati
Eric Kahn
Cincinnati
Don E. Levi
Cincinnati
Robert J. Meitus
Cincinnati
Youngsik Moon
Cincinnati
Uriel Remen
Cincinnati
Allen L. Straus
Cincinnati
Marianne Vas
Cincinnati

LICKING
Henry D. Rocco
Newark

MAHONING
Robert A. Bacani
Youngstown

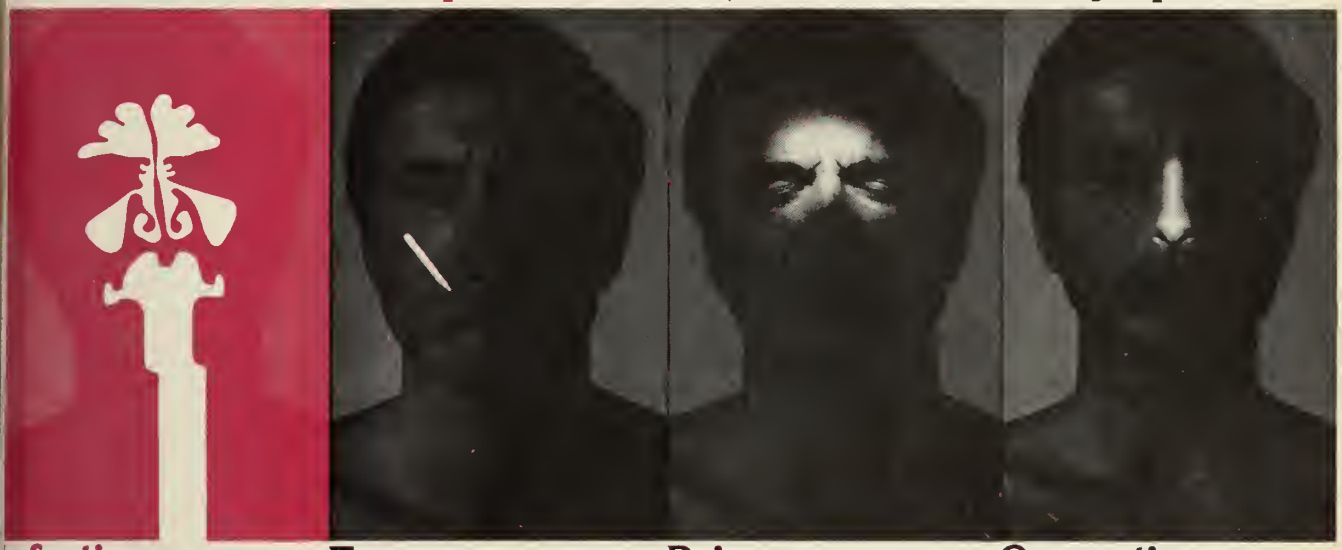
MONTGOMERY
Michael W. Craig
Dayton
Gary A. Fehrman
Dayton
Paul W. Grunenwald
Dayton
Chinn Woo Imm
Dayton
Burton G. Must, Jr.
Dayton
Mary Lou Marshall
Dayton
Ronald L. Nagy
Dayton
William J. Straughen
Dayton

SCIOTO
Davis E. Livingston
Portsmouth

SUMMIT
James R. Albright
Akron
Abbass Bagheri
Akron
M. Behrooz
Akron
Michael A. Flynn, Jr.
Akron
James M. Lewis
Akron
Anton P. Milo
Akron
Charles A. Peter
Akron
Ted Robertson
Akron
Francois W. Seguin
Stow
Leroy Tunnell, Jr.
Akron
Yenching Wu
Akron

'Group' therapy

for the bacterial complications of flu/U.R.I. and related symptoms



nfection
A broad-spectrum antibiotic to combat susceptible bacterial infections

Fever **Pain**
An analgesic/antipyretic to bring down fever, ease pain, and malaise

Congestion
An antihistamine for the symptomatic relief of nasal congestion

Tetrex® APC with Bristamin®

(tetracycline phosphate complex with analgesics and antihistamine)

For complete information consult Official Package Circular. (5) 4/2/70.

Indications: Upper respiratory infections due to sensitive bacteria where concomitant symptomatic relief of fever, malaise and congestion is desired.

Contraindications: Hypersensitivity to one or more components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used and serum estimations may be necessary during prolonged therapy. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Antihistamines may cause drowsiness and patients should not perform tasks requiring mental alertness while taking this agent. Bacterial or mycotic superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. Cases of gonorrhea with a suspected primary lesion of syphilis should have darkfield examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of 4 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur.

Usual Adult Dose: 2 capsules q.i.d. Children 6 to 12 years of age: ½ the adult dose.

Continue therapy for at least ten days in Group A beta-hemolytic streptococcal infections. Administer 1 hour before or 2 hours after meals.

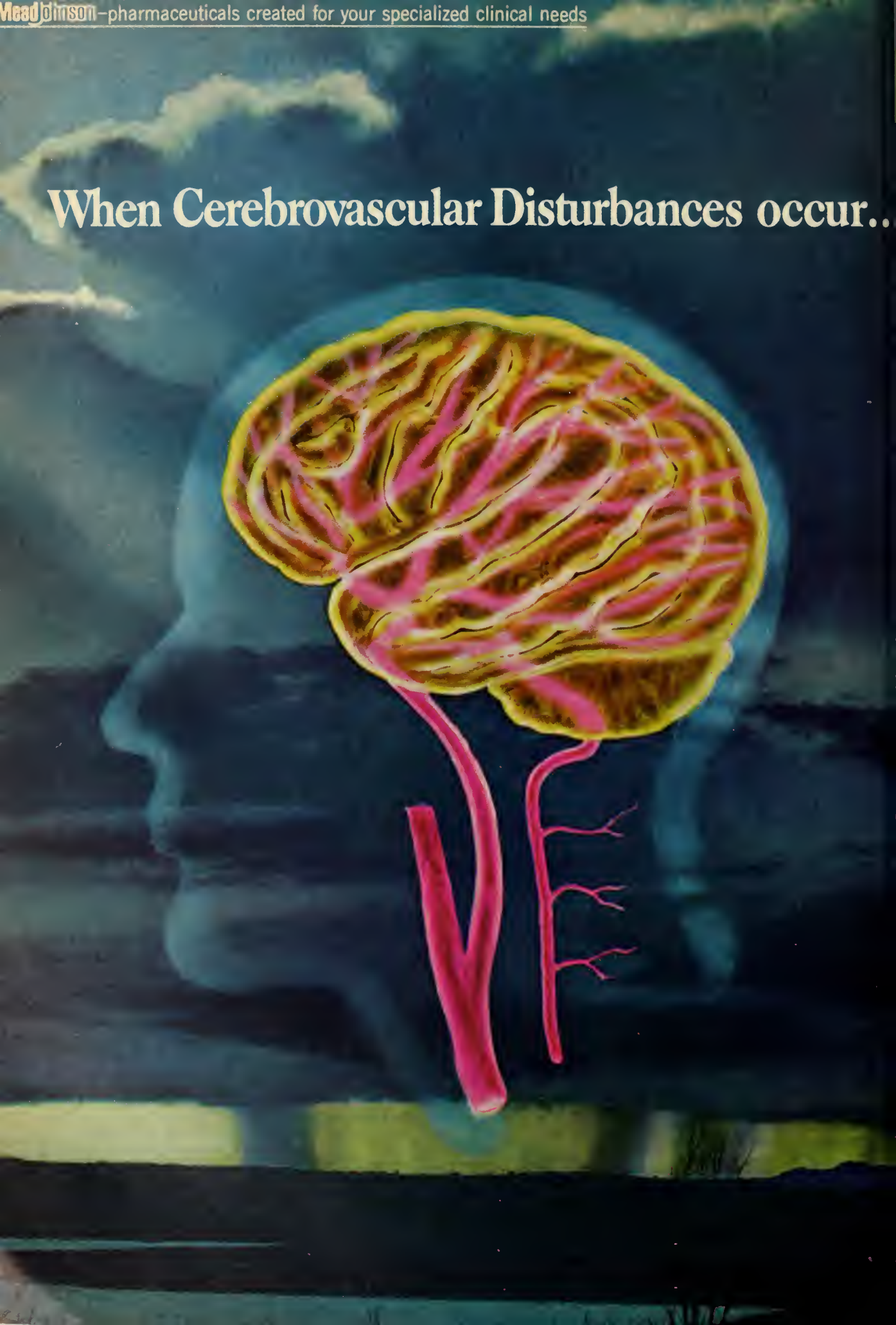
Supplied: Capsules—in bottles of 24 and 100.

A.H.F.S. Category 8:12

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

When Cerebrovascular Disturbances occur..



...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

VASODILAN®
(ISOXSUPRINE HCl)

to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow

New 20 mg. strength now available: Vasodilan 20 mg. tablets for greater dosage simplicity and convenience. Recommended *initial* dose: one 20 mg. tablet q.i.d.

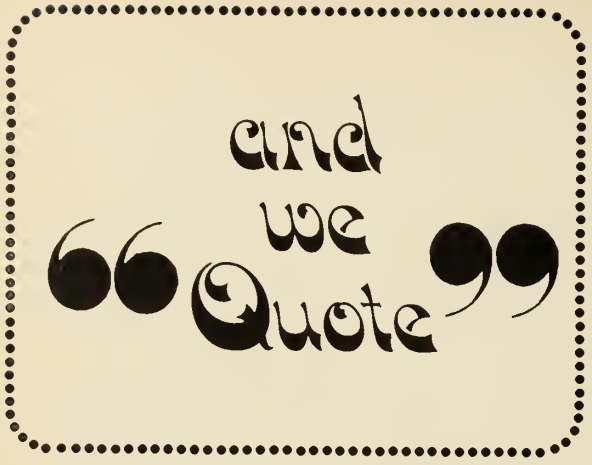
Although not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of isoxsuprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] and observation of clinical improvement.[2-4]

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, E. B., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

Mead Johnson LABORATORIES

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Medicine Can Speak with Voice of Authority

"We enter these crucial times with too many of our human institutions ill-adapted, confused or hopelessly bogged down by rules and traditions designed for other times and needs. Our leaders, liberal and conservative alike, are more concerned with imposing their conceptions of what they think ought to be, than they are with the real what is. The social sciences, those disciplines which should be primarily concerned with the realities of human nature and human behavior, have instead been largely preoccupied with attempts to design systems based on some theoretical concept of how things ought to be, rather than on how they are. By and large the professions have been backing away from their special responsibilities to an increasingly technologic and interdependent world society. . . .

"There is one profession, and only one, with the knowledge of human nature in health and disease and with the experience in human biology which will be needed, which can speak with the kind of authority which will be required, and within which there exists a dedication of purpose and channels of communication which transcend political boundaries. Medicine is that profession." — *California Medicine*

It Is Impossible to Promote a Phoney Product

". . . in today's increasingly strident and competitive society, we seem to be in danger of being press-agented and publicized and bullied to death.

"Every hot-line yahoo, every flag-waving (and flag-burning) dissenter and every campus protestor is promoting a particular point of view—often under the protection of the honored banners of free speech and a free press.

"The danger, it seems to me, is that the lines may become blurred between the valid and the specious, between the things of merit and the meretricious.

"For of one thing we may be certain—it is impossible to promote a phoney product.

"The corollary to that statement is that you can never bury a really sound idea." — Stuart Keate, publisher of the *Vancouver Sun,* as quoted in *Editor & Publisher*

Disposables and the Multibillion Item Junk Pile

"The time is coming when there will be a conflict between the comforts of disposables and a healthful environment hence we are not justified in tossing out billions of bottles and tin cans for some employees of government to collect and to dispose of in some manner. Workable solutions are difficult to devise. Citizens should reject the non-returnable containers. They should urge a deposit of ten cents on bottles and beer cans. If there were a substantial deposit on the containers, more of them would be returned instead of being tossed on lawns and along the highway.

"Probably, in the end we will need to resort to legislation requiring the return of all pop and beer containers or impose some hardship on the production of disposable containers that cannot be burned." — Charles Sellers, M.D., in the *Detroit Medical News*

Voluntarism Commended by Nation's First Lady

"You have accepted a great responsibility, for the many outstanding projects of the AMA auxiliary are of vital importance. . . . I am convinced that voluntarism in our nation can be highly successful with the commitment of such dedicated and effective groups as yours. I send my best wishes to you for a rewarding year in office." —Patricia Nixon, as quoted in *md's wife*

Something That Lies Beneath the Surface of Us All

"The headlong flight into informality and togetherness which characterizes our age has brought with it a consequent tarnish to that patina of quality: good manners. Deplorable when encountered in streets and shops, this slippage is

Sandoz announces...

a new agent for the alcohol-dependent patient who wants to quit

and

a program for the Ohio physician who wants to help





a major tranquilizer with specific advantages for the alcohol-dependent patien

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunctio or interfered with functional reco ery of impaired liver.
5. Four tablet strengths to allow flexibi ity of dosage (usual starting dose for the problem drinker, 10 mg. t.i.d. for the frank alcoholic, 25 mg. b.i.d.
6. Injectable form available for acute episodes.



program for early recognition and successful treatment:

Alcoholism in Ohio*

State Rank

total no. alcoholics	5th
no. per capita	13th
per capita consumption†	30th

Ohio Physicians' Report
(compared with U.S. average)

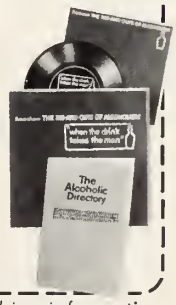
	%Ohio	%U.S.
see 5 or more problem drinkers in 2-month period	33.8	37.1
half or more seen are women	38.0	37.4
treat, rather than refer	73.7	72.6
more community services needed	64.0	63.0

*based on preliminary data supplied by Center of Alcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

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INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcahalics without producing hepatic dysfunctian ar hindering the functianal recovery of the impaired liver.

Schizaphrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity af Emotianal Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behaviarol Prablems in Mental Deficiency and Chronic Brain Syndrame: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychaneuratic Manifestatians: Serentil reduces the symptams af anxiety and tension, prevalent symptoms often assaciated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenathiazines Serentil (mesaridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals wha have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable ta administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits ta be derived fram treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe canditians for its use have not been established.

Attentian should be paid ta the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atrapine and phosphorus insecticides.

PRECAUTIONS: While acular changes have nat ta date been related ta Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration far bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ haur after injection.

Leukapenia and/or agranuiacytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drawsiness and hypotension were the mast prevalent side effects encauntered. Side effects tended to reach their maximum level of severity early with the exception of a few

SERENTIL®
(mesoridazine)
new weapon in the fight against alcoholism

(rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found amang thase patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators ta terminate treatment because of side effects.

Serentil has demonstrated a remarkably law incidence of adverse reactions when compared with ather phenothiazine compaunds.

Centrol Nervaus System: Drowsiness, Parkinson's syndrame, dizziness, weakness, tremar, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactians (opisthotonos) have been reparted.

Autanamic Nervaus System: Dry mouth, nausea and vamiting, fainting, stuffy nase, phataphabia, constipatian and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiavascular System: Hypatensian and tachycardia have been reported. EKG changes have occurred in some instances (see Phenathiazine Derivatives: Cardiavascular Effects).

Phenothiazine Derivatives: It should be nated that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the fallawing have accurred with one or more phenothiazines and should be cansidered whenever one af these drugs is used:

Autonomic Reactions: Miosis, obstipation, anarexia, paralytic ileus.

Cutaneaus Reactians: Erythema, exfaliative dermatitis, contact dermatitis.

Blaad Dyscrasias: Agranulacytasis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactians: Fever, laryngeal edema, angioneurotic edema, osthma.

Hepatotaxicity: Jaundice, biliary stasis.

Cardiavascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongatian af the Q-T interval, lowering and inversion of the T-wave and appearance af a wave tentatively identified as a bifid T ar a U wave have been observed in some patients receiving the phenathiazine tranquilizers, including Serentil (mesaridazine). Ta date, these appear ta be due to altered repalarizotion and not related to myocardial damage. They appear to be reversible. There is no evidence at present that these chang are in any way precursors of any significant d turbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arr has been noted.

Extrapyromidal Symptoms: Akathisia, agitoti motar restlessness, dystonic reactions, trism torticollis, opisthotonos, oculogyric crises, trem muscular rigidity, akinesia—some of which rare occasions have persisted for several mont or years especially in patients of advanced o with brain damage.

Endocrine Disturbonces: Menstrual irregularlti altered libido, gynecomastia, weight gain. Fal positive pregnancy tests have been reported.

Urinory Disturbances: Retention, incantinence.

Others: Hyperpyrexia. Behavioral effects sugg tive af a paradoxical reaction have been reporte These include excitement, bizarre dreams, agg vation of psychoses and toxic confusional stat More recently, a peculiar skin-eye syndrome h been recognized as a side effect fallowing lo term treatment with phenothiazines. This reacti is marked by progressive pigmentation of are of the skin or conjunctiva and/or accompanied discoloration of the exposed sclera and corn Opacities of the anterior lens and corneo scribed as irregular or stellate in shape ho also been reparted.

DOSAGE AND ADMINISTRATION: Oral: The d age of Serentil (mesoridazine), as in most me cations, should be adjusted to the needs of t individual. The lawest effective dosage shou always be used. When maximum response achieved, dasage may be reduced gradually a maintenance level.

Alcahalism: For most patients the usual starti dose is 25 mg. b.i.d. The usual optimum to daily dose range is 50-200 mg. per day.

Schizaphrenia: For most patients, regardless severity, a starting dase of 50 mg. t.i.d. is rec mended. The usual optimum tatal daily dose ran is 100-400 mg. per day.

Behaviarol Prablems in Mentol Deficiency a Chronic Brain Syndrame: Far mast patients a st ing dase of 25 mg. t.i.d. is recommended. T usual optimum tatal daily dose range is 75-300 per day.

Psychoneuratic Manifestatians: Far mast patients t usual starting dase is 10 mg. t.i.d. The usual o mum tatal daily dose range is 30-150 mg. per d

Injectable Form: In those situations in which intramuscular farm af medication is indicat Serentil (mesoridazine) Injectable is available. I most patients a starting dose of 25 mg. is rec mended. The dose may be repeated in 30 ta minutes, if necessary. The usual optimum total do dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 n and 100 mg. mesoridazine (as the besylate). E tles of 100.

Ampuls: 1 cc. [25 mg. mesaridazine (as the be ate)]. Inactive ingredients—Disodium Edeta U.S.P., 0.5 mg.; Sadium Chlaride, U.S.P., 7.2 m Carbon Diaxide Gas (Bone Dry), q.s.; Water Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 1

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particularly regrettable when displayed about our hospitals.

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Medical Ethics and the Patient's Pocketbook

"The sins that are committed in the name of cost accounting to determine what should be fair service charges may not all be willful but they are hard on the patient's pocketbook. To add to all this; both attending physician and house staff are often unexcusably careless in ordering expensive procedures when they are not really necessary (for instance, a brain scan in one hospital costs $100.00). There are times when this may be of critical importance in making a diagnosis but, if Blue Cross or the government were not paying the bill most of these and other unduly costly tests often would and could be avoided.

"Why are these considerations brought up in a discussion of medical ethics? It is because to be a party to anything which is not to the best interest of our patient is unethical."—John W. Trieschmann, M.D., in the *Journal of the Arkansas Medical Society*

The Video Orb and the Jaundiced Viewpoint

"The color trademarks of NBC and ABC are respectively a peacock and a red-white-and-blue monogram. After "The Promise and the Practice" and "Don't Get Sick in America," we have a suggestion for CBS: Be sure to get enough yellow in that video orb to portray accurately the network's jaundice against American medicine.

"The two hour-long documentaries were editorials, pure and simple. The viewpoint was clear: CBS is all-out for national compulsory health insurance, closed panel practice, reorganization of care, and about everything else antiestablishment to medicine."—*Journal of the Mississippi State Medical Association*

Sees Group Practice as the Good Life

"Many physicians, especially the young physicians, recognize that their professional aspirations and their design for living can be accomplished best by joining a medical group. The young physician is able to start with a full practice, an insured income, and the necessary diagnostic and therapeutic equipment. His working schedule can be arranged to permit time for his family, for planned continuing education, and recreation. The physician has easy access to consultants and has the assurance that when he is not available, his patients will be cared for by a member of the group.

"Most of the larger groups also provide an opportunity for the physician to teach and/or participate in investigative work. In a medical group, even though located in a rural community, one can practice his specialty in a stimulating environment without fear of medical isolation." —Walter I. Buchert, M.D., in *Pennsylvania Medicine*

Subjective Viewpoint and the Health Care Dollar

"American medicine is acutely aware of the cost picture in providing health services. Every medical organization worthy of its name has pledged to provide the best care consistent with conservation of the health care dollar. - - -

"Obviously, no sugar-coated explanation makes more palatable spending money for something you don't want in the first place, illness or injury. Such outlays are usually unplanned, too, and health care expenditures often deny us something we would much rather have. After all, who wouldn't, at this season of the year, rather buy a new outboard motor than have his gallbladder out?

"But we do need to communicate and safeguard. This is the positive story which needs telling."—*Journal of the Mississippi State Medical Association*

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"A paper-thin voice is a powerful persuader." —Hammermill Paper Company.

Psychosomatics—Two Sides of the Healer's Coin

". . . many contemporary errors and prejudices were once a part of scientific medicine. This knowledge also gives us an insight into the methods and ideas of quacks, often the best students of psychosomatic illness."—Professor Wilhelm Loeffler, Zurich, in the *World Medical Journal*


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Clinical & Scientific Features







VOLUME 66 SEPTEMBER, 1970 NUMBER 9

Recent Developments in Laser Technology of Interest to the Practitioner

LEON GOLDMAN, M.D.

IT IS of considerable interest now for the practitioner to know about some of the modern developments in laser technology. Many are familiar with the use of the laser in ophthalmology and current research in laser surgery. These will be discussed later. However, recent advances in laser technology should be of interest not only to those practitioners who are concerned with occupational medicine and the military but also to those interested in the world of today and tomorrow.

It is now ten years after the discovery of the laser. While some advances in applications are spectacular, outside of the military it is still having a difficult time. "The areas where lasers have attempted to make their initial inroads are some of the most conservative, tradition-bound sectors of American industry—medicine, metalworking, surveying." *(Electronic Products Magazine,* November 1, 1969, p. 120). The cardinal rule, not only in industry but in our research has been, "If you don't need the laser, don't use it." However, in the military, holography, communications, and computers and, recently in art, lasers are finally showing their specific merit.

The Author

• **Dr. Goldman, Cincinnati, is Professor and Chairman, Department of Dermatology, University of Cincinnati College of Medicine; and Director, Medical Laser Laboratory of the Medical Center, University of Cincinnati.**

The Lasers

The practitioner should be aware, especially since the high school physics student already knows that there are many lasers, not just one. They vary all the way from the ultraviolet far into the infrared. They are beams of light produced by stimulated emission of radiation. All are strong and precise. Their efficiency is low. For high-output systems, tremendous electrical energies are needed. For low-output systems, as in the new experimental laser cane for the blind, self-contained small batery units supply the power for the gallium arsenide lasers in the cane.

Additional recent developments, essentially for research instrumentation, are of interest since

From The Medical Laser Laboratory, established by the John A. Hartford Foundation at the Children's Hospital Research Foundation of the Medical Center of the University of Cincinnati.

Submitted March 13, 1970.

these instruments do not need such expensive set-ups. An example is the chemical laser, where the self-contained chemical reaction produces the stimulation for laser emission. Tunable lasers, that is, those developing any frequency desired from a single type of instrument, paper feasibility work on x-ray laser systems, and the role of the laser in thermo-nuclear fusion experiments are but a few of the current studies. The most significant is the thermo-nuclear fusion phase. This is done by providing very hot plasma needed to initiate such a reaction in deuterium. This brings the laser into the field of nuclear medicine. In this connection, much paper (and bench?) work is being done in the possibility of stimulating emission in the x-ray region of the spectrum to produce x-ray lasers. Such instruments, fortunately, are not available today. Although these would furnish third-dimensional x-ray pictures and details of the molecular structure of matter, their destructive powers would be beyond comprehension.

Safety

All are familiar with the Apollo 11 experiments, with the use of retroreflectors on the surface of the moon reflecting back Q-switched ruby (red) and pulsed argon (blue-green) laser beams. This is the area of communications and is of interest to the military as well as space programs. There is increasing concern among the public about the hazards of lasers in atmospheric propagation of these beams. The hazards concern eye damage. Patients may ask practitioners about this. How strong are these laser rays which go to the moon and are reflected back? In our current research with Q-switched ruby lasers for the treatment of tattoos, we are using Q-switched ruby, with energy densities 6 to 14 joules per sq. cm. Similar laser systems, used to impact the retroreflectors on the moon, are approximately twice as strong as these. As these are projected high in the sky, they diffuse rapidly as they reach the moon. Then they are to be reflected back and are weak but strong enough to be detected only by special instruments. It is assumed that even for aircraft pilots who fly high, or their passengers, that the eye exposure to such laser beams is not excessive. A warning was issued recently to pilots in regard to the laser irradiation from the McDonald Observatory near Fort Davis, Texas. More work is being done in this phase because of the increasing uses of lasers for tracking, ranging, and even communications. Current experiments are being done in detailed safety programs at present. In brief, then, there are no hazards to the public. It is necessary to repeat, that in the use of any laser system, eye protection is most important. Detailed studies have been done on guidelines for safe exposures of the eyes and also of the skin.

Another current phase of the atmospheric propagation of laser systems is the new field of the laser as a visual art. This is being studied extensively for the first time at the Cincinnati Art Museum. Here, artists are working with the laser in design, holography, interferometry (pictures of interference patterns by lightwaves), sculpture, and photography. Detailed testing has been done to assure the safety of such techniques, especially for the artist himself and for the general public. Tests by the Laser Laboratory, by the Bureau of Occupational Safety and Health of the U.S. Public Health Service, and the Cincinnati Health Department have established the safety of this for the viewing public. The toxicity of the thermal decomposition products in laser sculpture in plastics is also of concern.

Holography

A fascinating and important field of current laser technology at present is holography, third-dimensional imagery without the use of lenses or cameras. A picture of interference patterns, hologram, in film or glass, when viewed with proper illumination shows in space a third-dimensional image. Even multiple colors are possible. This hologram is produced by the marked coherency of the laser beam. Eye hazards are present in the development of the hologram and, when lasers are used for illumination, in the reproduction of this. However, there have been such advances in technique that often the laser is not used for the reproduction of these fascinating images in space, just ordinary light and, at times, ordinary polychromatic light sources. This technique of holography is being developed for signs in the air along highways, turnpikes, and in factories. Fascinating stress patterns may be shown in metals. In data recording, holography has made it possible to store "two and one-fourth million bits per square inch." It is believed possible to increase this to "six million bits per square inch." RCA has announced recently a color tape cartridge and cartridge player for a TV set to be available in 1972. A holographic image is put on a vinyl tape. Color reproduction is done through gratings superimposed on the hologram. A two-milliwatt helium laser reconstructs the hologram and a TV camera also in the playback unit attached to the television set picks up the laser reconstructed hologram. How this will all turn out in comparison with its rival, electronic video recording technique, remains to be seen. The special image reconstruction attachment of RCA will be enclosed so even though a low-output laser is used, there will be no hazard of laser radiation for the viewer. Also, modern color television sets are constructed now with minimal hazards of x-ray radiation exposure for the viewer and also for the TV service man.

Holography is used in our laboratory to study third-dimensional patterns of strains and stresses

on bones. In biology, holographic microscopy is used to develop third-dimensional images of the growth patterns of the living cell. The laser attached to a miscroscope may be used for spectroscopy of living tissues, cells, and even intracellular components. This is done without complete destruction of the tissue or even the cell. For the future, the hospital laboratory will be able to do detailed analyses of calcium, phosphorous, iron, etc., from small drops of dried blood. The argon laser attached to a microscope now also can do microsurgery, even on selected areas of larger chromosomes. A whole new field of cellular biology is now being developed. Acoustical holography, a combination of ultrasound and laser holography, is being used to produce third dimensional pictures of the inside of solid objects. This is under study now for visualizations of bones and tumors.

Industrial Applications

Current developments in industry include also the use of the laser in metal work, welding, cutting, and drilling. Most of these are in closed systems, where the reflectant beam from the laser and where the metal plume particles from the laser reacting in metals present no hazards. However, if such metal drilling and working is done out in the open, those in industrial occupational medicine must be concerned with industrial hygiene of the hazards for the eye and skin, and for air pollution.

Other applications of the laser in industry at the present time include the helium-neon laser for measuring and for directional use for lining up pipe laying, tunneling, etc. Most of these lasers are not strong, but direct beam visualization should not be done. Weak infrared laser systems are under study in the automobile industry now as types of radar systems, warning systems for obstructions ahead or in back, etc. In any area of occupational medicine, detailed knowledge of the process must be acquired both by the doctor and by the industrial hygienist.

Another concern in laser safety of interest to the practitioner is the use of laser kits by the hobby crowd, often without adequate warning about the eye hazards. Some of these laser kits provide for fairly high output lasers, especially with the ruby laser systems. Complete lasers are now being advertised for purchase by the lay public. Some of these do not provide for adequate safety precautions. There is now legislation at the federal level, and in some areas at state levels, for detailed protection from lasers and for registration of lasers. On January 16, 1970, the Federal Radiation Control Act (PL 90-602) became effective. This new law concerns, in addition to lasers, x-rays, TVs, microwave ovens, electron microscopes, vibrators, oscillators, etc. A special teaching course on laser safety, under CONMED of the College of Medicine and the Laser Laboratory of the Medical Center of the University of Cincinnati, is scheduled for August, 1970.

Medical Applications

Briefly, the current status in laser medicine of interest to the practitioner includes significant advances in laser surgery of the eye, now with the argon laser, and especially in laser treatment of progressive diabetic retinopathy and mainly in the juvenile diabetic. Such laser surgery prevents extensive spread of the damaging neovascularization induced by hypoxia. There is now in production a new green-light laser photocoagulator for the eye. This is the frequency doubled yttrium aluminum garnet (YAG) laser, 530.0 nm. The argon laser may be more constant in its output and more flexible.

Laser surgery in man continues to be used for tattoos, especially with Q-switched laser systems. For the laser treatment of the resistant port wine birthmark lesions, children are now being treated under general anesthesia. Because of primitive quality of the current laser instrumentation, only small linear port wine spots can be treated in a practical fashion; the large ones require many treatments over long periods of time. Melanoma, rarely primary, continues to be treated by the laser. The serious prognosis of widespread metastases still remains, although the local lesion itself, accessible or made accessible to the laser beam, can be treated effectively. In man, local melanoma can be treated without the dissemination of melanoma foci from the impact area of the pulsed laser. Such local spread does occur in melanoma animal tumors. Multiple basal cell epitheliomas continue to be treated with the laser. Laser epilation is also under investigation and pilot instruments are now available for clinical research. Laser transillumination is being studied for studies in the infant, for the diagnosis of soft tissue tumors, and for cancer work and is being compared to x-ray mammography and xerography. Laser colpomicroscopy in now under investigation in our laboratory for the research and development of instrumentation for more effective visualization and therapy of pre-invasive carcinoma of the cervix. Similar instrumentation is being developed for early cancer in other accessible areas.

In our laboratory, laser cardiovascular surgery with the CO_2 laser has been done by Naprstek in dogs. This type of laser system has been used all the way from the thoracotomy, down to the inside of the heart, without other instruments, for control of bleeding. One phase of this work has been the production of a precise test model system for partial or complete heart block. Siler, Director of Laser Surgery, and Naprestek are doing extensive studies in CO_2 laser hepatic surgery of the dog to

establish the parameters of such important surgery. This is of interest now because of the increasing frequency of liver damage from seat belt injuries from deceleration in automobile accidents. Similar studies are being done by Wangensteen and his associates at Minnesota. Here, studies are done also in experimental gastric surgery. Hobeika, of the Division of Otolaryngology and Maxillofacial Surgery, has been using the laser for investigative laryngectomy and hypophysectomy in dogs. Bone fusion by CO_2 laser for bone grafting is under study by Miller of the Department of Orthopedics.

All these studies in our laboratory have been with the American Optical CO_2 laser. Basic studies on laser surgery and wound healing have been studied by Hishimoto, also of our Laser Laboratory.

A detailed program of safety for laser surgery has been established by Altemeier, Siler, and Fidler in cooperation with the staff of the Laser Laboratory. The Laser Laboratory of the Medical Center of the University of Cincinnati has been the center of studies on laser safety and, with the U.S. Public Health Service, has initiated two international conferences on all phases of laser safety. A third conference to include also microwaves and ultraviolet light is planned with the U.S. Public Health Service in 1971. This conference will include also safety programs for microwave and ultraviolet irradiation. A course on laser applications in biology and medicine will be given at the Medical Center in 1971. With planned programs, then, the laser is safe for the patient and the operator.

More effective instruments must be made available for use in biology and medicine. Such instruments are now available for military and industrial uses. More extensive applications of lasers for medicine must await the availability of these and the development of laser biomedical centers. Consequently, laser advances in biology and medicine have suffered. Only by adequate advances in laser biology and medicine can effective safety programs be developed. So, again, the need for a special institute for medicine and biology is emphasized here with close and meaningful lines of communications, with the multiple disciplines of physics, engineering, instrumentation, biophysics, industrial hygiene, and medicine. This is necessary for future progress of planned safety programs and for the expected advances of the laser in biology and medicine.

The practitioner, then, must be informed and kept informed. He must be able to advise his patients, who are often disturbed by sensational headlines.

HYPERURICEMIA IN HYPERTENSIVE PATIENTS. — A group of 18 patients with mild to moderate hypertension, receiving 1.0 gm of chlorothiazide per day, were treated with 300 mg of allopurinol daily for a two-week period. A changeover design was employed in which a two-week period on placebo was substituted for allopurinol. The level of serum urate rose from 4.8 to 5.7 mg per 100 ml with chlorothiazide and placebo; this value was reduced to 3.5 with addition of allopurinol and was accompanied by an approximate decrease of 25 percent in uric acid excretion.

Since hyperuricemia has been suspected as a cause of renal disease it might seem advisable to prevent its induction during therapy of hypertension, particularly since hypertensive patients tend to high uric acid levels. On the other hand, introduction of still another medication to the already heavy therapeutic load that the hypertensive patient must carry, with its attendant potential for side effects over a long period of treatment, warrants hesitation in the prescription of allopurinol as a routine measure in patients who are receiving thiazides.—James A. Nicotero, M.D., et al, Pittsburgh, Penna: *The New England Journal of Medicine,* 282:133-135, January 15, 1970.

Some Perspectives in Biomedical Engineering and Artificial Organs

S. D. Moulopoulos, M.D. and W. J. Kolff, M.D.

SINCE it would be unwise to make a specific program for a period longer than ten years, let us consider what may be the most probable advances in the field of biomedical engineering in the near future.

Three main fields exist, in which contributions are predictable: (A) instrument construction, (B) artificial organs or components for replacement of diseased parts of the human body, and (C) the study of the human systems for a more objective and thorough understanding of their construction and function. Progress in the first field may aid mainly the diagnosis, while in the second, treatment will be helped. Progress in systems investigations will probably help both procedures indirectly.

For illustration, a few examples will be given of what is apt to be accomplished in each group.

(A) *In the instrument field,* we are in need of a reliable device for measuring flow, especially if this could be mounted on a catheter for intravascular use. Measurement of arterial and venous pressure, without puncturing the vessel, is becoming important for the continuous monitoring in intensive care units. It should be possible to construct the proper primary sensors.

The diagnosis of atherosclerosis is another example of future possible exploration. If we can detect particles in outer space, it should be possible to detect damage in the arteries within the body. Rushmer is already busy adapting ultrasonic devices for the purpose.

A neglected diagnostic field is the one including the skin and its diseases. It is probably the most striking example of the medical profession's indifference to contemporary technology. Dermatology is still relying on eye and sense of touch to examine an organ that is so easily accessible for objective, quantitative measurement of its mechanical properties.

(B) *In the artificial organs field,* one may envision the day in which the four main systems dealing with circulating the blood and processing its ingredients, namely, the heart, the lungs, the kidneys, and the liver will be replaced en block by a single unit including a pump, an oxygenator, hemodialyzer, and a chemical processing device. Actually the first three artificial organs now available in crude form could be incorporated in one

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Submitted March 7, 1970.

block. This would facilitate the insertion of an artificial heart and eliminate its pulmonary circulatory problems. If the four-organ system could be "fed" by processed food materials (i.e. intravenously), the digestive tract would be indirectly replaced. Since the endocrine gland function is already replaced by giving hormones, only the brain and the reproductive organs will remain irreplacable.

The combination of a hemodialyzer and an oxygenator can replace most of the functions of the placenta. The time is near that babies now suffocating with hyaline membrane disease will be sustained with an artificial placenta until their lungs recover. Examples of relatively minor projects in this field will be: the replacement of heart valves without opening the chest (by valves mounted on catheters to correct regurgitation) and closed-chest valvulotomy using small knives also mounted on catheters to correct stenosis.

It has been demonstrated that perfusion of the coronary arteries with arterial blood improves cardiac function in animals in cardiogenic shock. A small pump implanted between the aorta and the coronary arteries might do just that.

It should be predicted, however, that organ replacement may not be physiologically successful, if the mechanical-biochemical aspect of the system's function is not better understood.

The artificial kidney, which opened the era of artificial organs, unquestionably prolongs most of the patients' lives. It does not, however, restore them to complete health and it may not do so until the function of the natural kidney is better understood and until the artificial kidney is able to remove all the substances responsible for uremia and can be applied continuously rather than intermittently.

Surgeons have said that the main difficulty in the artificial heart project is the blood material interface. One of us believes that when this problem will be solved, the patients with artificial hearts may still die of what one could call "the artificial heart syndrome," unless we learn to understand better the heart function in relation to the peripheral vascular system. The surgical and the physiological approaches to these problems are different, and they should be integrated.

These arguments should not delay progress in the construction of artificial organs. They are brought up only to indicate the necessity of simultaneous work by competent, progressive, and properly educated people in an integrated way.

(C) *As to the study of human systems,* for a more objective understanding of their construction and function, the approach to these problems by medicine should indeed imitate the logical approach that other sciences are using. The problems may be immense and a systems analysis should be the first step. To give an example, the computer analysis of the function of the human arm by the Temple University group was later used for the functional control of a prosthetic arm.

Computer analysis of a televisioned image married to a computer-analyzed chart of the light-sensing cortex of the occipital lobe of the human brain may one day lead to an actually seeing artificial eye.

SURGICAL MANPOWER. — There are twice as many surgeons in proportion to population in the United States as in England and Wales, and they perform twice as many operations. Fee-for-service, solo practice, and a more aggressive therapeutic approach appear to contribute to the greater number of operations in the United States. More frequent use of consultation, closely regulated and standardized surgical practices, and restrictions in facilities and numbers of surgeons appear to contribute to the lower rates of operations in England and Wales. Indications for surgery are not sufficiently precise to allow determination of whether American surgeons operate too often or the British too infrequently. Determination of surgical manpower needs requires better information on how much operative treatment the public health requires and must also take into account the total medical manpower needs of the country.—John P. Bunker, M.D., Stanford, Calif.: *The New England Journal of Medicine,* 282:135-144, January 15, 1970.

Vocal Rehabilitation After Total Laryngectomy

The Asai Procedure

Andrew W. Miglets, Jr., M.D.

CARCINOMA OF THE LARYNX has a high cure rate, if it is diagnosed early and treated aggressively. Although several cancer operations have been developed in which vocal function is preserved, they are only effective in patients with small lesions. Unfortunately, the majority of patients with carcinoma of the larynx have large tumors when diagnosed and are not candidates for these conservation procedures. In them, total laryngectomy usually offers the best chance of obtaining a cure.[1]

Although the surgical morbidity and mortality rates with total laryngectomy are low, the thought of loss of vocal function has a profound psychologic effect. The fear of becoming mute may even cause patients to delay surgery until their tumors have reached a large size, or it may cause them to seek a less effective method of treatment.

After total laryngectomy, vocal rehabilitation may be established by esophageal speech. In this method of speaking, air is swallowed and eructated into the pharynx, where speech is produced by the lips, tongue, and palate. The quality of voice produced ranges from fair to good. Unfortunately, not all laryngectomy patients are able to learn esophageal speech.

Formerly, there were only two avenues of communication left open to these patients. The first was by writing, which is slow, frustrating, and inconvenient; the second was by using a mechanical device, which when held to the neck produced vibrations that could be converted into speech. These devices have the disadvantage of producing a voice which is a flat, mechanical monotone with no range of pitch, making it impossible to put inflection into sentences or emphasis on certain words. Also, battery replacements may be costly, some patients spending over $100 per year.

Submitted January 12, 1970.

The Author

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Laryngectomy patients, who have not mastered esophageal speech, now have a third choice. This is by an operation that connects the trachea to the hypopharynx with a small dermal tube. When the patient wishes to speak, he simply occludes his tracheal stoma and exhales. The air column passes up the dermal tube and enters the patient's hypopharynx where speech is produced by the lips, tongue, and palate. The quality of voice produced is usually good to excellent. Aspiration is not a problem, although most patients must compress the dermal tube when they eat. This procedure was first described by Dr. Ryozo Asai of Kobe, Japan, and later popularized by Dr. Alden Miller,[2,3] who recently presented eight patients, all with good voices.

The Asai Procedure-Method

The initial step in performing the Asai procedure is to create two tracheal openings when

the laryngectomy is performed. The upper stoma is formed by suturing the edges of the trachea to the skin. The lower is made by forming a trap door of the anterior tracheal wall and swinging it out through the connective tissue to the skin. The bridge of cartilage insures that the stoma will remain open. These openings should be separated by at least 2½ cm. of skin (Fig. 1). The upper stoma will later be connected to the pharynx, while the lower will remain open as the patient's permanent airway. Patients at this stage are no different from those who have had a standard laryngectomy. Before proceeding with the second stage of the Asai procedure, we observe the patient for three months. This allows complete healing to occur and, more importantly, gives the patient a chance to develop esophageal speech. If no progress is made toward learning esophageal speech, the second stage is done. Patients who learn esophageal speech do not need the Asai procedure, and one of the tracheal stomas is closed.

The second stage of the Asai procedure is to create a cutaneous pharyngeal fistula (Fig. 2). This is done by elevating skin and mucosal flaps, which are sutured together. The pharyngeal opening of this fistula must be located just beneath the overhang formed by the base of the tongue. This overhang will later direct food away from the opening into the dermal tube, decreasing the possibility of aspiration. The cutaneous pharyngeal fistula is usually kept open with a plastic stent. The patient is observed for several weeks until complete healing occurs, as evidenced by a skin to mucosal closure with no sign of granulation tissue. The stoma initially should have a diameter between 7 and 8 mm. Stricture formation will usually decrease it to 4 mm, the ideal size.

When it appears the pharyngocutaneous fistula will remain open, the third stage is performed. Skin flaps are fashioned so the upper tracheal and pharyngocutaneous fistula can be connected with a dermal tube (Fig. 3). Care is taken not to elevate the flaps too near the midline, which would compromise their blood supply. The dermal tube is usually closed around a Portex stent which is

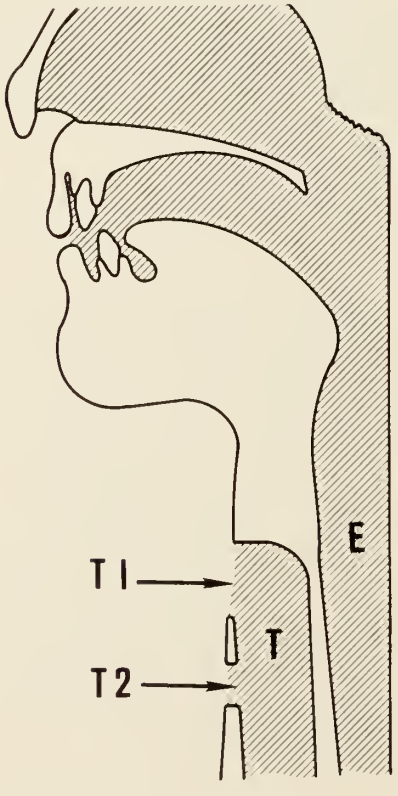


Fig. 1. The first step in the Asai procedure is to make two tracheal openings at time of laryngectomy. Upper stoma (T1) will later be connected to the pharynx, the lower (T2) will serve as the permanent airway. Note location of trachea (T) and esophagus (E).

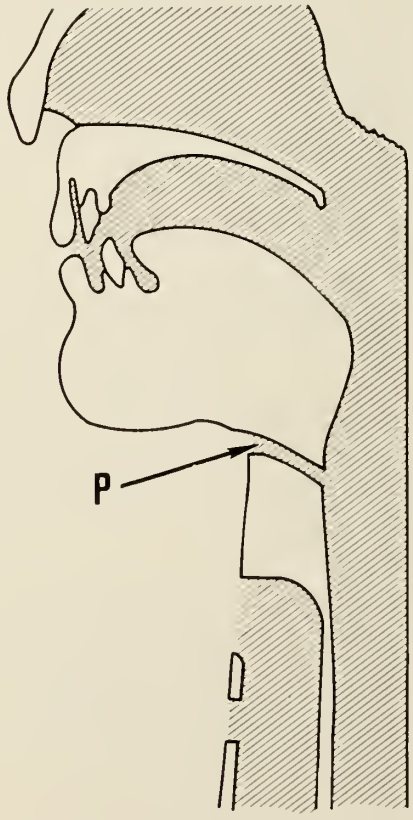


Fig. 2. Second stage of Asai procedure is to create a cutaneous-pharyngeal fistula (P). Note pharyngeal opening is placed beneath overhang formed by base of the tongue.

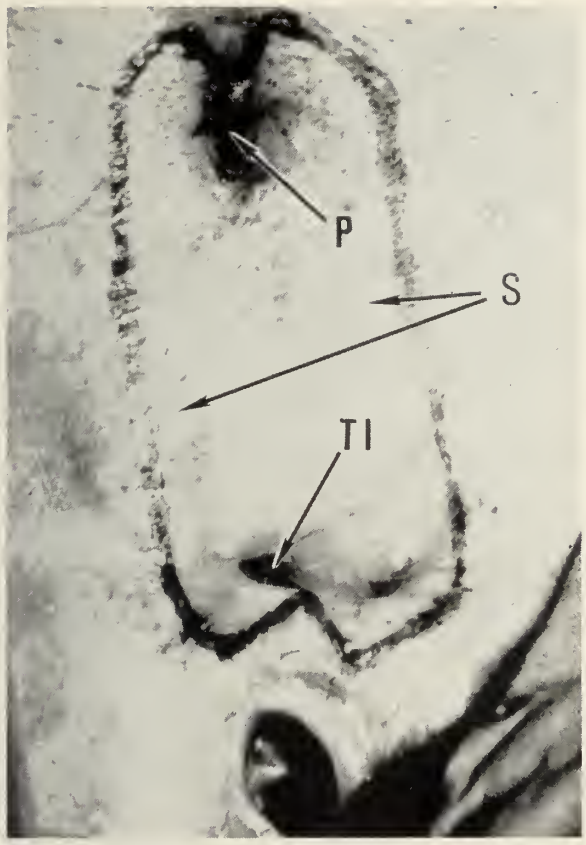


FIG. 3. Skin flaps (S) are outlined so upper tracheal (T1) and pharyngo-cutaneous fistula (P) can be connected.

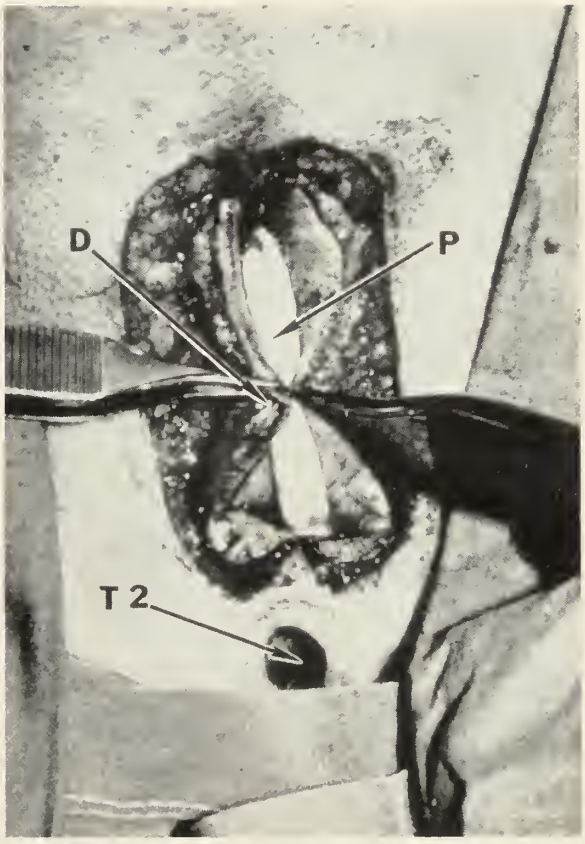


FIG. 4. Dermal tube (D) is usually closed around a Portex stent (P) which is left in place for six weeks. T2 represents the lower opening into trachea which will serve as patient's permanent airway.

left in place for six weeks (Fig. 4). At this stage of the operation, if the surgeon occludes the patient's tracheotomy tube (even with the plastic stent in place), the patient is able to speak. Primary closure over the dermal tube is accomplished by undermining the surrounding skin and advancing the edges (Figs. 5 and 6). If this is not feasible, a chest flap may be rotated to cover the raw defect.

When the patient wishes to speak (Fig. 7), he simply places his finger over his tracheal stoma and exhales. An air column passes up the dermal tube into the hypopharynx where speech is produced.

Results

The Asai procedure has been attempted in nine patients. We have completed the procedure in four. All have good to excellent voices and do not aspirate, although when eating they must manually compress the dermal tube. The slight inconvenience of having to occlude the tracheostomy stoma while talking is not a problem. After several days, this action becomes automatic. Respiratory infections have not occurred with our patients, nor with those described in the literature.[4] The quality of voice produced varies between individuals but, as a rule, is better than esophageal speech and far superior to the mechanical devices. They are able to produce a wide variety of sounds and to put enough inflection into their sentences so that those from southern Ohio have retained their characteristic accents.

The failures were due to technical problems. In three patients, the bridge of skin between the tracheal stoma broke down, making it impossible to form the dermal tube. The procedure was attempted in one patient who had previous radiation therapy. We were not able to create the dermal tube due to poor healing of the radiated tissues. This has been the experience of others, and at present, preoperative radiation is felt to be a contraindication for this procedure. One patient developed recurrent tumor.

The main technical problem occurs during

the second stage. At times, it is difficult to keep the cutaneous-pharyngeal fistula open. The body has a great tendency to close all fistulas and one must be absolutely sure that the tracheal cutaneous fistula will remain open before proceeding with the third stage of the procedure. If this precaution it not taken, troublesome stenosis of the dermal tube may occur.

Discussion

The idea of vocal rehabilitation in laryngectomy patients by creating an opening between the trachea and esophagus is not new. In 1939, J. C. Beck[5] described a patient who created his own tracheo-esophageal fistula by placing a red hot ice pick through the back wall of his tracheal stoma into his esophagus. He kept this fistula open with a goose quill until healed. Strangely, the patient had no aspiration problem, and Dr. Beck stated the quality of his voice was better than any esophageal speech he had ever heard. Many years later, Conley[6] devised a procedure in which a tunnel lined with mucosa or autogenous vein was formed between the trachea and esophagus. This tract was directed downward to prevent aspiration when the patient swallowed. Because the air column entered the esophagus low, the quality of voice was only fair, much the same as esophageal speech.

Kolson and Glasgold[7] described a patient with a postoperative tracheo-esophageal fistula which healed except for a small defect located at the superior aspect of the tracheal stoma. This communicated with his upper esophagus. He had an excellent voice and had no trouble with aspiration as long as he wore his tracheotomy tube.

Although, tracheo-esophageal fistulas may be used for voice production, they are usually unsatisfactory because of the associated aspiration. Since the Asai procedure forms a superficial dermal tube, which is easily compressed while eating, these patients do not have this problem.

We feel that all patients following total laryngectomy should be encouraged to develop esopha-

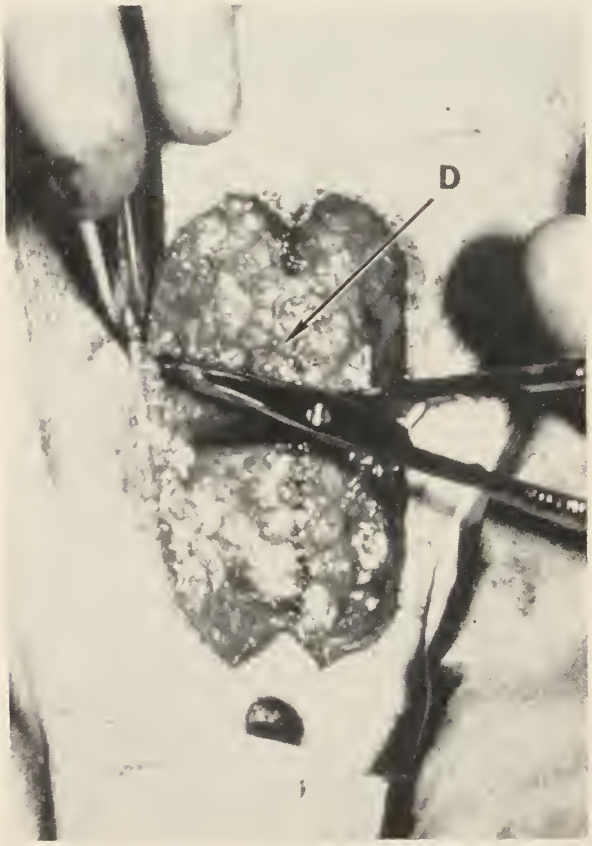


Fig. 5. Dermal tube (D) has been closed. Surrounding skin is undermined so the edges can be advanced, thus covering the defect. If this is not feasible because of a previous neck dissection, it may be covered with a flap rotated from the chest.

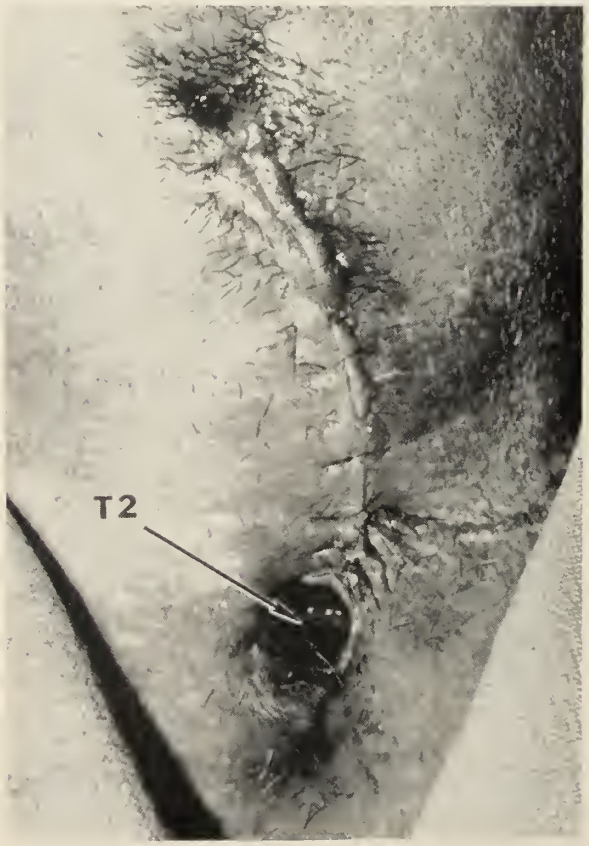


Fig. 6. One week following surgery. Skin has been closed over the dermal tube. Note lower tracheal opening (T2) is intact and will serve as patient's permanent airway.

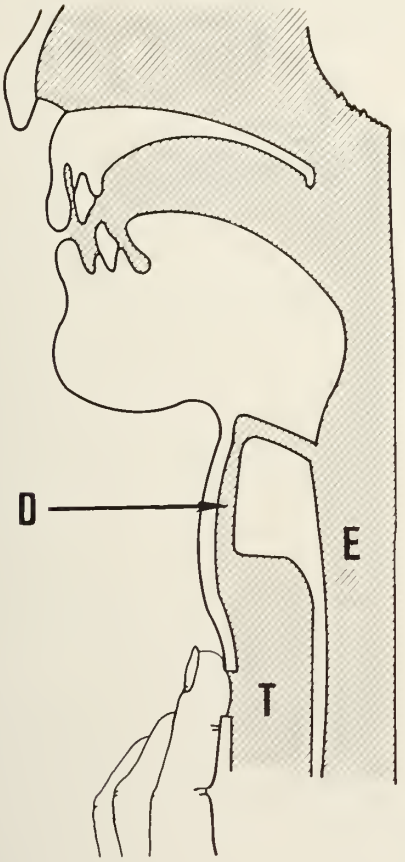


Fig. 7. When the patient wishes to speak, he simply places his finger over his tracheal stoma and exhales. The air passes up the dermal tube (D) into the hypopharynx where speech is produced.



Fig. 8. Contrast radiograph illustrating the dermal tube (D) which connects the trachea (T) with the hypopharynx (H). Esophageal inlet (E) is also seen.

geal speech. If they are unable to accomplish this, the Asai procedure can be considered. Patients who have had this operation do have the inconvenience of having to occlude their tracheal stoma when they talk, and compress the dermal tube when they eat. Also, instead of one, there are three operations with a rather long convalescent period. Of course, most patients who have lost vocal communication are more than happy to endure these inconveniences.

At present, our philosophy is to either create a high tracheal stoma or two tracheal openings when we do a laryngectomy. We then encourage the patient to develop esophageal speech. If he is unable to do this, then he may be converted to the Asai procedure.

Some long term laryngectomy patients who have remained mute may also be converted to the Asai procedure. The pharyngocutaneous fistula and the second opening into the trachea may be done at the same operation. They are later connected in the usual manner.

Summary

Our experience with the Asai procedure has been presented. This is an excellent means of vocal rehabilitation following total laryngectomy in patients who have not developed esophageal speech.

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Tracheal Stenosis

A Review of Four Cases

Seungwoo Rho, M.D., and John F. Viljoen, M.D.

THERE HAVE BEEN many reports of tracheal stenosis occurring after tracheal intubation, both via the larynx and through a tracheostomy. During the past three years, four such cases have been treated at the Cleveland Clinic Hospital. The clinical material was analyzed retrospectively and efforts were made to elucidate what the possible causes might have been.

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Clinical Material

Case 1. A 54-year-old man sustained a cardiac arrest during cardiac catheterization at another hospital on August 3, 1969. During the successful resuscitation a cuffed orotracheal tube was introduced and breathing was maintained by a mechanical ventilator. The patient was kept intubated for 48 hours. Two and one-half months later he experienced progressive breathing difficulty. By November 13, 1969, the patient's condition had deteriorated to such an extent that emergency admission to the Cleveland Clinic Hospital was necessary. Bronchoscopy revealed treacheal stenosis and immediate corrective surgery was performed. The strictured portion, less than 4.5 mm. in diameter extending 2 cm. in length, was found 3 cm. above the carina.

Case 2. A 58-year-old woman underwent open heart surgery for mitral and tricuspid valve replacement and open aortic commissurotomy on August 1, 1968. The patient was intubated with a latex-covered red rubber cuffed orotracheal tube. At the end of the operation, the rubber tube was removed and a polyvinyl cuffed nasotracheal tube was inserted, since postoperative ventilatory insufficiency was anticipated. This problem persisted, and, one day later, a tracheostomy was performed and a nylon #7 tracheotomy tube was inserted. The tracheotomy tube was in place for a total of six days. Six weeks after the tracheotomy, she noticed that her breathing became difficult and noisy; this progressed, and on December 26, 1968, bronchoscopy revealed a markedly strictured trachea about 5 mm. in diameter and 1.5 cm. in length at the level of the previous tracheostomy scar. Corrective surgery was performed the same day.

Case 3. A 61-year-old man sustained bilateral rib fractures when a tree fell on him. An emergency tracheostomy was done in a local hospital on July 18, 1967 and a double-cuffed rubber tracheotomy tube was used. The patient's respiration was assisted for 21 days, following which extubation was performed. Seven weeks after the tracheostomy, he experienced some breathing difficulty. Bronchoscopy one month later revealed a stenosed trachea 4 mm. in diameter, 1 cm. in length, and 6 cm. above the carina. Another tracheostomy was done, and efforts were made to dilate the stenosis using a No. 6 and 7 metal tracheostomy tube. Finally, on November 7, 1967, the patient underwent corrective surgery.

Case 4. This 51-year-old man underwent a bilateral internal mammary artery implant on July 20, 1967. Nasotracheal intubation was employed using a cuffed polyvinyl endotracheal tube 8.5 mm. in diameter. Following operation, the patient was maintained on controlled ventilation for 24 hours before extubation was performed. From the fifth postoperative day, the patient experienced hoarseness and noisy breathing. One month later bronchoscopy revealed a granulomatous mass on the left vocal cord. The tissue was pruned with some alleviation of symptoms. The difficulty recurred, and laryngeal disease having been demonstrated, emergency tracheostomy was performed on September 4, 1967, utilizing a polyvinyl tracheostomy tube. It was noticed that the trachea was already narrowed at this stage. This tube was left in for a total of 40 days. After removal of the tube, breathing difficulty reappeared and became progressive. Bronchoscopy on November 20, 1967 revealed

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tracheal stenosis 7 mm. in diameter with local congestion and edema at a level 2 inches above the carina. On December 11, 1967, the patient was submitted to corrective surgery.

Results

Table I shows the age and sex distribution of the patients reviewed. Also tabulated are the duration of intubation prior to the performance of the tracheostomy, the total number of days the tracheostomy tube was in situ, and finally, the site at which the stenosis was found.

Pathology of the strictured portion:

1. Fibrocartilaginous portion with chronic inflammation.
2. Marked fibrosis with chronic inflammation.
3. Chronic inflammation and productive fibroplasia of mucous membrane.
4. Fibrous squamous metaplasia and chronic inflammation.

Surgery performed:

Circumferential resection of the strictured portion with end-to-end anastomosis of trachea.

Discussion

Tracheal intubation has become increasingly popular as a means of providing an airway for general anesthesia, and is considered necessary whenever intermittent positive pressure ventilation is required for any more than very short periods of time. While the benefits of tracheal intubation are considerable, and in many instances lifesaving, complications do sometimes occur, of which tracheal stenosis is one of the more serious.

The etiologic factors that have been implicated in the development of tracheal stenosis are as follows: (1) problems associated with the cuff; (2) erosion of the trachea by the tip of the tube; (3) fibrosis at the site of the surgery; (4) chemical irritation; (5) infection; and (6) trauma due to the passage of suction catheters.

1. Inflation of the Cuff. With the increasing use of cuffed endotracheal or tracheotomy tubes, tracheal stenosis is being more frequently encountered. The fact that overinflation of tracheal cuffs will cause pressure necrosis has long been recognized. Unfortunately intracuff pressure was not measured in any of our cases; but so far as we can ascertain, the principle of inflating the cuff with a minimal occluding volume (MOV) was observed in all patients. MOV is defined as the volume determined by inflating the cuff to the point at which no audible air leak could be detected when a positive-pressure ventilation of about 30 cm. of water was applied to the tube.

In case 1, the cuff was kept inflated continuously for 48 hours; in case 2, intermittent deflation of the cuff was performed for three to four minutes each hour; in case 3, a double cuffed tube was used and the cuff was kept inflated continuously for 24 hours. It will be noted that despite the differences in management of the cuff inflating technic, tracheal stenosis still ensued.

The practice of intermittent deflation and inflation of the cuff is theoretically attractive, but unless the minimal occluding volume is determined each time inflation is performed, overdistention of the cuff will occur. Therefore it might well be safer to maintain a constant accurately determined MOV for long periods. A device has recently been developed which allows intermittent inflation, so that the cuff is inflated during the inspiratory phase and deflated during expiratory phase. Clinical and experimental evidence suggests that this may represent a significant advance.

Efforts have been made to reduce the intracuff pressure without affecting the airtight seal. A technic of prestretching the cuffs has been described; it was shown that at an airway pressure of 30 cm. of water, the standard tracheostomy cuffs provided airtight seals at intracuff pressures of 270 to 358 mm. Hg. Using prestretched cuffs the above intracuff pressure fell to 30 to 82 mm. Hg.

The effects of cuff inflation are obviously compounded by poor tissue perfusion; thus we may expect to encounter this problem more often in cardiac patients or in those who are hypotensive from other causes.

2. Erosion of the Trachea. Erosion of the trachea by the tip of the tube is probably more common when silver or nylon tubes are used. Excessive movement and misplacement would aggravate this problem. The lesion tends to be localized, and it

Table I. Data on Patients Reviewed

Patient	Sex	Age	Time Tube Retained Oro- or Nasotrach.	Tracheostomy (Days)	Location of Stricture
1	M	54	48 hours		Cuff Level
2	F	58	28 hours	6 days	Stoma Level
3	M	61		21 days	Cuff Level
4	M	51	28 hours	40 days	Cuff Level

is felt that our cases could not be explained on this basis.

3. Fibrosis at the Site of the Surgery. One of our patients developed stenosis in this area. There seems to be a correlation between the amount of tracheal circumference that is sacrificed, the size of the tube introduced through the stoma, and the incidence of stricture formation. That the first tracheal ring should be avoided is an established principle. These cases are relatively easy to treat surgically.

4. Chemical Irritation. The method of sterilization used for the tubes was exposure to a mixture of 12% ethylene oxide and 88% freon for 4 hours at 125°F. We originally quarantined PVC tubes for 36 hours at 70°F in a well-ventilated environment. Studies have indicated that ethylene oxide may persist in such materials as plastic, rubber, and leather, etc. for several hours and, in some instances, for several days.

The major hazard of ethylene oxide sterilization is inadequate aeration. Residual ethylene oxide and its by-products ethylene glycol and ethylene chlorohydrin are highly irritant to tissues and have been known to cause tracheal inflammation and necrosis from intubation with tracheostomy tubes, burns of the face from anesthesia masks, and of the hands from rubber surgical gloves. Hemolysis of blood in pump-oxygenators and giving sets have been reported.

The time required to eliminate ethylene oxide from the sterilized plastic or rubber materials is a minimum of seven days stored at room temperature, and 12 hours at 50°C with properly designed aeration. Three-milliliter thick polyethylene wrapping and paper wrap is a satisfactory packaging material. Nylon film is not very permeable to ethylene oxide and should not be used.

Recent work has suggested that our original aeration time may well have been insufficient, and we cannot rule out completely the possibility that ethylene oxide sterilization was a contributory factor in the production of tracheal damage.

There has been some recent work showing that certain stabilizers used in the manufacture of polyvinyl chloride may leach out of plastic and produce tissue necrosis. This subject is currently under review.

5. Infection. While all the specimens that we obtained of the stenosed area showed a chronic inflammatory response, it is unlikely that infection was indeed the primary event.

6. Trauma Due to Suction Catheters. Trauma due to the suction catheter probably would have produced lesions at a lower level than was found in the cases under review.

Based on our findings in this admittedly small series, it would appear that the site of stricture was most frequently found in the area of the cuff. The question arises as to whether we should use cuffed or uncuffed tubes. In adults, uncuffed tubes render the regulation of ventilatory volume somewhat difficult, and there is always a possibility of foreign material entering the tracheobronchial tree past the tube: it is suspected that the larynx may not fulfill its normal protective function satisfactorily in the tracheostomized patient. We feel that the utilization of cuffed tubes in adults continues to be justified, and further investigation will elucidate how the complications arising from inflation of the cuff may be avoided.

Summary and Conclusion

Four cases of tracheal stenosis are presented; three developed this complication at the site of the cuff. Pressure necrosis is suggested as being the most likely primary event. Overinflation of the cuff is an ever present hazard in even the most carefully managed areas.

Tracheal stenosis is surgically correctable, i.e., resection of the stenotic portion with end-to-end anastomosis of the trachea; postoperative follow-up studies should be done routinely as stenosis may redevelop at the site of the anastomosis.

We feel strongly that if any patient who has had endotracheal intubation (or tracheostomy) with cuff inflation, complains of noisy or difficult breathing, he should be thoroughly investigated for tracheal stenosis with a view to surgical correction.

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Self-Evaluation Quiz

1. Among the following, the chief difference between breast milk and cow's milk is:
   (A) The caloric content
   (B) The iron content
   (C) The vitamin D content
   (D) The protein content
   (E) The fat content

[*From the Department of Pediatrics, University of Cincinnati College of Medicine. The answer is given on p. 932 of this issue.—Ed.*]

2. How old would you expect a child to be if he could copy on paper a circle, cross, and square but not a triangle or diamond?
   (A) 2 years
   (B) 3 years
   (C) 4 years
   (D) 5 years
   (E) 6 years

[*From the Department of Pediatrics, University of Cincinnati College of Medicine. The answer is given on p. 932 of this issue.—Ed.*]

3. The most common cause for persistent hypertension in childhood is:
   (A) Renal parenchymal disease
   (B) Coarctation of the aorta
   (C) Cerebral edema
   (D) Turner's syndrome (gonadal dysgenesis)
   (E) Pheochromocytoma

[*From the Department of Pediatrics, University of Cincinnati College of Medicine. The answer is given on p. 932 of this issue.—Ed.*]

Bilateral Noncalculous Ureteropelvic Obstruction

Report of a Case Associated with Anuria

Bruce H. Stewart, M.D. and Robert L. Boltuch, M.D.

URETEROPELVIC OBSTRUCTION is one of the most common congenital anomalies of the urinary tract. Severe obstructions usually become apparent early in life, whereas milder degrees may not produce symptoms until later. Total anuria as a result of ureteropelvic obstruction, even in a solitary kidney, is extremely rare. A case of anuria secondary to bilateral noncalculous ureteropelvic obstruction, with satisfactory recovery of renal function following bilateral pyeloplastic procedures, is here reported.

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Case Report

This 54-year-old white housewife was referred to the Cleveland Clinic on July 13, 1965 for evaluation of intermittent right flank pain for two years. The pain was usually aggravated by standing and relieved by recumbency.

Physical examination was normal except for a marked kyphoscoliosis, a systolic bruit heard in the right upper quadrant, and mild right flank tenderness. Blood pressure was 160/110 mm. Hg.

Laboratory data included a hemoglobin level of 11.8 gm. per 100 cc., serum creatinine of 2.4 mg. per 100 cc., and blood urea nitrogen levels which varied from 50 to 80 mg. per 100 cc. Serum electrolytes were normal. Urinalysis revealed 2 to 4 white blood cells and occasional red blood cells per high power field. Urine culture was negative. Intravenous pyelogram showed poor visualization bilaterally and was inadequate for diagnostic interpretation.

Cystoscopy revealed a large capacity bladder, with multiple inflammatory pseudopolyps present at the vesical neck. The ureteral orifices were normal, and the urethra calibrated at 30 French. Retrograde pyelography (Fig. 1) showed mild dilatation of the left pelviocaliceal system with narrowing of the ureter at the ureteropelvic junction; the right renal collecting system was partially obscured by the scoliotic spine, but appeared unobstructed. Delayed films showed some retention of contrast medium in the left renal pelvis after two hours, but good drainage on the right, which was the side of her pain.

For evaluation of the hypertension and abdominal bruit, transfemoral selective renal angiography was performed. There were mild nonocclusive atherosclerotic changes present in both main renal arteries, with marked stretching of the interlobar arteries on the left, suggesting either multiple cysts or possibly hydronephrosis. Similar but less obvious stretching of the interlobar arteries was noted on the right. However, marked scoliosis prevented optimal delineation of these vessels, and vascular detail was insufficient to rule out the presence of aberrant arteries to the lower pole of either kidney.

The patient was treated conservatively. Although she still complained of intermittent right flank pain, the urine was sterile and renal function remained unchanged. However, on November 13, 1965, she came to the emergency room with a 24-hour history of severe flank pain, nausea, chills, and inability to void. She was afebrile, and physical examination revealed mild bilateral flank tenderness. Urethral catheterization revealed no urine to be present in the bladder. Hemoglobin was 12.1 gm. per 100 cc. and blood urea concentration had increased to 95 mg. per 100 cc. Serum bicarbonate was 16.3, chloride 103, potassium 6.7, and sodium 125 mEq/liter. Emergency cystoscopy and retrograde pyelograms were performed. These revealed bilateral obstruction at the ureteropelvic junction, beyond which catheters could not be advanced (Fig. 2).

Transabdominal renal exploration was then performed. On the left side, there was an aberrant artery to the lower pole with severe angulation of the left ureter about 1 cm. below the ureteropelvic junction, resulting in total obstruction. The obstructed segment was resected, a dismembered pyeloplasty was performed, and nephrostomy drainage was established. The contralateral kidney was palpated, and the renal pelvis was found to be greatly distended.

Postoperatively, the urine output via nephrostomy tube was excellent, and the blood urea concentration fell promptly to 41 mg. per 100 cc. Twelve days later a right transabdominal renal exploration was performed. There was a 1.5 cm. stenotic segment of the right ureter just distal to the ureteropelvic junction. In addition, there was an aberrant vessel to the lower pole which crossed anterior to the ureter but did not in itself appear to be causing complete obstruction. A dismembered pyeloplasty was performed and the ureter was splinted with a #7 French polyethylene catheter, which had been inserted previously by cystoscopy. Her postoperative course was uneventful, and all tubes were removed within two weeks.

During the three years since surgery, she has remained asymptomatic, with sterile urine, and blood

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Fig. 1. Initial retrograde pyelogram showing dilatation of left pelviocaliceal system; right kidney partly obscured by scoliotic spine, but appears unobstructed.

urea nitrogen and serum creatinine levels averaging 28 and 1.9 mg. per 100 cc, respectively, Excretory urography in August, 1969 demonstrated satisfactory function in both kidneys.

Discussion

Congenital ureteropelvic obstruction may be bilateral in 10 to 20 percent of cases,[1] and occasionally it may occur in a solitary kidney. Intermittent flank pain and vague gastrointestinal symptoms are common presenting complaints, and in some cases infection or uremia may develop. However, anuria as a result of noncalculous congenital ureteropelvic obstruction is extremely rare.

In 1949, Ormond and Best, in a review of 27 cases of anuria, reported the case of a young woman who was suddenly unable to pass any urine.[2] For some months prior to the onset of anuria she had suffered attacks of pain in both loins. On examination there was no urine in the bladder, there were large masses palpable in the flanks, and the nonprotein nitrogen was elevated. Bilateral nephrostomies followed by ureteropelvic plastic operations were performed and she lived for several years before dying of renal insufficiency.

Our own case demonstrates again that intermittent hydronephrosis can develop bilaterally and



Fig. 2. Retrograde pyelogram showing bilateral complete obstruction at level of ureteropelvic junction, beyond which catheters could not be passed.

simultaneously to the point of complete obstruction and anuria. Such obstructions are usually unilateral and quite painful,[3] but in our case the pain was relatively mild. Prompt correction of the obstruction by staged reconstructive procedures has resulted in resumption of adequate renal function.

Although rare, noncalculous congenital obstruction of the ureteropelvic junction should be considered a possibility in the differential diagnosis of patients with sudden onset of anuria, especially if there is a history of previous attacks of flank or abdominal pain.

Summary

Noncalculous obstruction of the ureteropelvic junction, although rare, may occur bilaterally or in a solitary kidney and may result in acute and total anuria. Immediate operative correction of the obstruction can restore satisfactory renal function in some cases.

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Angiocardiography

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ANGIOCARDIOGRAPHY is the radiographic examination of the heart (cardiography) and blood vessels (angiography). Areas of interest are rendered radio-opaque by contrast agents which absorb more x-ray than surrounding body tissue. Vascular structures injected with these substances appear relatively white on a darker background.

Angiocardiography employs a variety of equipment and methods, and the approach selected must be individualized to the problem at hand. Four factors require special consideration:

(1) *Contrast Agent.*—Radiographic contrast agents are organic iodine compounds of low toxicity, which can be used safely in total doses of up to 1.5 to 2 ml. per kg. body weight during a single examination. Obviously, the injection of smaller individual amounts permits a greater number of injections. This is highly desirable, especially in the examination for multiple sites of disease. Prior to injecting a large bolus, a small test injection should be made. Fall in blood pressure, systemic reaction, or local infiltration may require discontinuation. Mild reactions such as nausea, headache, and hypotension are common but transient. Urticaria is infrequent, and anaphylactic reaction extremely rare. Most side effects require no treatment other than close observation.

(2) *Manner of Delivery.*—Originally, angiocardiography was performed by the injection of a large volume of contrast material into a peripheral vein. This has been obviated by catheterization techniques in which the tip of a catheter is positioned (under fluoroscopic guidance) in the structure to be studied. This technique is termed "selective angiocardiography" and is preferred because it permits the use of much smaller volumes of contrast material, and it provides superior visualization of anatomic detail by avoiding opacification of overlapping structures.

Use of a catheter demands relatively high pressures for rapid delivery and the use of an automatic power injector. Smaller arteries (or veins) permit a choice of either powered or manual injection.

(3) *Radiographic Recording.*—The image intensifier fluoroscope, with its attached closed circuit television system, produces an image up to 4000 times brighter than the conventional fluoroscope, yet with lower amounts of radiation. This permits superior visualization and precise positioning of catheters. A videotape recorder attached to the system provides magnetic tape recording of all events for immediate review or for permanent storage. Photographic recording is preferred for the final diagnostic interpretation, however, since the photographic image is sharper than the television image. Either 35 mm. or 16 mm. cine film exposed at 30 or 60 frames per second is used for the permanent recording of the angiocardiogram (cinefluorography).

When rapid filming is not of critical impor-

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tance and fine anatomic detail is a more significant objective, the study may be recorded on large (14 x 14 inch) films serially exposed in rapid sequence (up to 12 per second) by means of an automatic film changer. This system is capable of producing film quality comparable to the conventional roentgenogram. Both methods, cinefluorography and serialography, are complementary and should be available in any angiographic laboratory.

(4) *Care Of Patient.*—Angiography is performed with the patient's safety and comfort in mind. Ordinarily, these procedures are accompanied by a minimum of discomfort and a very low morbidity. The angiographer sees the patient before the procedure to explain the study and allay anxiety and to apprise himself of any clinical information which might influence the method of approach.

Under local anesthesia, the catheter may be introduced either percutaneously or following exposure of a vessel. Thereafter, the patient is generally unaware of the catheter's presence as it passes through the great vessels or into the heart. Injection of contrast agent is accompanied by variable sensations of warmth, depending upon the site and quantity of injection. Monitoring of the patient after catheterization is routine and rarely requires special attention.

To achieve optimum results with minimum morbidity, angiography should be conducted only by experienced physicians (cardiologists or cardiovascular roentgenologists). Adequate monitoring and emergency equipment should be available, including as a minimum, electrocardiographic and pressure monitoring devices, a D.C. defibrillator, oxygen, endotracheal tubes, suction apparatus, and drugs to combat hypotension, sensitivity, reactions, and rhythm disturbances.

Angiography

Angiography is performed by injecting a contrast agent in or close to the region of interest. Partial obstruction of a blood vessel appears as a segment of reduced caliber, and complete obstruction appears as an abrupt termination. Frequently, however, the contrast agent bypasses the area of obstruction through collateral vessels and opacifies the distal segment of the diseased vessel as the collaterals reenter. Information thus gained about the length of the obstructed segment and the status of the vascular tree beyond is of utmost importance in planning possible surgical correction.

Occlusive vascular disease is seen commonly in the carotid, renal, pelvic, femoral, popliteal, and coronary arteries. Larger vessels such as the aorta, caval veins, and pulmonary arteries may also be involved and are similarly studied. Angiography is also useful in the study of tumors, hemorrhagic states, vascular anomalies, portal hypertension, and certain organ diseases.

Angiocardiography

The chambers of the heart, not distinguished by routine radiography, may also be opacified so that radiographic estimation of internal size, shape, wall thickness, and emptying becomes possible.

Myocardial Disease. — Myocardial scarring from previous infarction or diffuse fibrosis is seen as a zone of reduced or absent contractility. Further weakening of the myocardium results in paradoxical motion as seen with ventricular aneurysm. In these cases, the thinned portion of the myocardium bulges outward during ventricular contraction, resulting in a saccular dilatation. The opposite condition, that is abnormally thickened or hypertrophied myocardium, is seen as a consequence of increased work-load (e.g. left-to-right shunts, valvular insufficiency), outflow resistance (e.g. systemic hypertension, aortic or pulmonary valvular, postvalvular, or subvalvular stenosis), or from unknown cause (e.g. non-obstructive hypertrophic cardiomyopathy).

Congenital Heart Disease.—Opacified blood passing through intra or extracardiac shunts or through anomalous vessels reveals the size, location, and anatomy of the abnormalities. Stenotic lesions, such as coarctation of the aorta and pulmonic valvular stenosis, are readily demonstrated by the injection of the opaque medium proximal to the lesion.

Valvular Diseases.—When valvular insufficiency is suspected, the contrast medium is injected distal to the valve. Incompetence of the valve is demonstrated by a stream of opacified blood leaking back through the closed valve. The amount of reflux may be graded. Conversely, injection proximal to a stenotic valve allows estimation of the size of the orifice.

Conclusion

Angiocardiography has become one of the clinician's most useful diagnostic tools. Rapid advances in catheter technology and development of angiographic knowledge have established this technique as an indispensable diagnostic discipline and already have earned it a place among the classic advances in medicine. The recent dramatic progress in cardiovascular surgery has depended in great measure on this modality. Further improvements in methods, contrast agents, and radiographic equipment may be expected to extend present capabilities even further. Maximum benefit to the patient, however, depends upon the awareness of the clinician as to the proper place of this method in the study of disease and on the skillful performance of angiocardiography.

Cardiac Disease in Pregnancy*

Byron K. Cole, M.D.

SINCE the earliest years of its operation, The Committee on Maternal Health, OSMA, has conducted a state-wide study of maternal deaths on a continuous basis. Members have kept cognizant of various trends in the statistical prevalence connected with certain primary causes of *maternal deaths* in Ohio. Facts and features associated with predominant fatal conditions have been publicized by The Committee from time to time, as a medium of education.

The potential hazards connected with *cardiac disease in pregnancy* have appeared so *marked* in the Ohio Study, that The Committee has labelled *this* lady "The High Risk Obstetric Patient."[1] Finally, members developed the idea of preparing a health exhibit, of similar title, to display facts and features gleaned from experience with the Ohio Maternal Mortality Study, during its first 12 years. The exhibit (Fig. 1) was presented at the Annual OSMA meeting in Columbus.[2] Data in the following tables and charts appeared in the exhibit.

The problem of cardiac disease occurring in the gravid patient is understood best if one first reviews the physiologic changes that occur in normal pregnancy. It is these changes that often cause a well-compensated cardiac patient to decompensate during the gravid period.

At least four changes are of paramount importance, e.g., an increased *cardiovascular output,* an increase in *plasma volume,* an increase in *total body water* and *increased work* of labor and delivery.

There is some controversy over the factors resulting in an increased cardiac output, but most investigators seem to focus attention on the development of a large arterial-venous shunt in the placenta (Table 1). Thus, the heart must work harder than prior to pregnancy, and significantly so since approximately 25 percent of the cardiac output traverses this new shunt. It is thus easy to understand how a borderline compensated patient might decompensate under these circumstances. An interesting phenomenon in the natural history of this shunt is that it reaches its peak in size at about the *eighth* month, thereafter diminishing in size as the small vessels comprising it begin to obliterate during the final weeks of pregnancy. Based on this change alone, the cardiac patient would have more difficulty during the seventh and eighth month than during the final month. However, other factors that make vigilance important are *operative,* as we shall see, throughout the pregnancy and also in the puerperium.

The second factor mentioned above is that of increased plasma volume. (Table 1). This is an approximate 50 to 65 percent increase, and, accordingly, causes an increase in cardiac work. The greatest plasma volume occurs at about the seventh month, with a slow decline occurring until term.

Total body water increases to a level approximately 20 percent above normal. This factor, of course, is somewhat similar to the increase in plasma volume in terms of increased cardiac work.

The final major factor to consider is the increase in work during labor and delivery. Work

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

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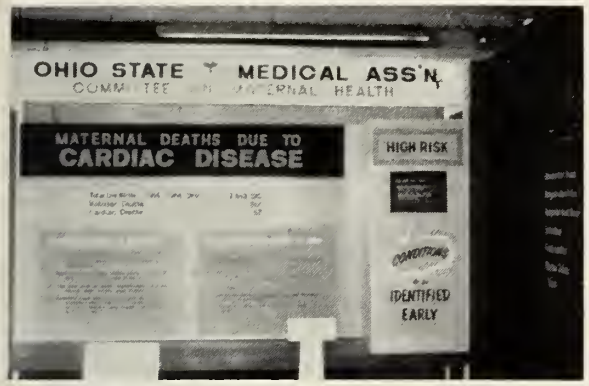


Fig. 1. Exhibit H-105, "Maternal Deaths Due to Cardiac Disease," shown at OSMA Annual Meeting, May 12, 1970.

during this time may be tremendously increased, but is intermittent, reaching its peak during uterine contractions. Nonetheless, total work done per minute may be quite great! Furthermore, the heart must continue to work harder for an hour or more after the second stage of labor to alleviate the oxygen debt built up.

After delivery, several hemodynamic events occur to increase the workload on the heart. Blood volume is increased due to the extravasation of blood from the placenta to the general circulation. After the placenta is removed, there is an increase in peripheral resistance, since the presence of the placenta during pregnancy had generally reduced the peripheral resistance. Finally, there is a greater venous return to the right side of the heart secondary to increased muscular contraction during labor.

A few comments should be directed toward the occurrence of certain signs and symptoms during pregnancy that may appear to be due to congestive heart failure but which in fact are not. Swelling of the ankles is common even in women without heart disease. What is known of the circulatory changes resulting in edema is quite interesting. Though enlargement of the uterus with subsequent pressure on the veins leading from the legs is a factor, an increase in venous pressure in the veins of the lower extremities has been found long before the uterus increases significantly in size. It appears that *early hormonal changes* produce an increase in blood flow to the developing fetus and uterus. The venous return from the pelvis to the inferior vena cava, therefore, is *increased*. This increased flow causes some impedance of flow from the extremities, thus increasing the venous pressure in the latter.

Dyspnea also is commonly experienced in pregnancy, and, though probably due to a number

Table 1. Cardiac Physiologic Changes in Pregnancy, OSMA Exhibit May 12, 1970.

1. Cardiac output increases 30 to 50%. Peak increases at 30 to 34 weeks. Gradually approaches normal before term. Major reason: an A-V shunt at the placenta.
2. Blood volume increased—plasma volume increases 50 to 65%. Increase reaches a peak at the seventh month.
3. Total body water increased—approximately 20% above normal. Water reaches peak at term.
4. Increased oxygen cost of breathing—probably due to increase in breast size, limited diaphragmatic excursion, lordosis, when oxygen consumption is at peak, etc.

of factors, certain of these are more clearly understood than others. For example, it has been shown that the increased size of the breasts leads to increased cost of breathing, thus producing the sensation of dyspnea (Table 1).

General Management

Both the cardiologist and the obstetrician should jointly dedicate their skills in the constant observation of the patient *simultaneously* throughout her pregnancy (Table 2). Here the *number* of necessary visits for the patient is only equalled by the *quality* of care rendered by the two physicians.

Management of the gravid cardiac patient is based on accurate diagnosis of the heart disease and classification according to the New York Heart Association.

In Classes I and II, activity need not be severely restricted. This does not mean, however, that these individuals do not benefit from additional rest!

Activity must be more restricted in Class III patients, and in Class IV patients, hospitalization during the latter part of the pregnancy is advisable.

With the development of more potent diuretics, the question of sodium restriction becomes a moot point. Certainly, patients with more severe failure should restrict sodium intake as any severe cardiac should.

The use of digitalis generally should be guided by the same principles that guide one in using this medication in any patient. Generally, therefore, a patient should show some evidence of failure before digitalis is administered. In a few instances, though, prophylactic digitalization might be justified.

In patients with rheumatic heart disease, prophylactic antibiotics should be administered, and aggressive antibiotic management of acute infections should be undertaken early. Remember that acute infection in rheumatic heart disease is often a precipitating factor in congestive heart failure.

It should be emphasized again that a tremendous workload is experienced during labor, and

it may be at this time that the first signs of congestive failure are noted. On the other hand, the first signs may not appear until after delivery. The point is that congestive heart failure may occur at *any time during pregnancy or shortly thereafter* in the patient with heart disease. In fact, she should be continued under protective cardiac care for at least two weeks after delivery (Table 2)!

Regarding the question of cesarean section in gravid cardiac patients, it is generally accepted that sections should be done only for obstetric reasons, rather than medical. If the patient has been watched closely during her pregnancy and treated appropriately, she should tolerate vaginal delivery well. Careful application of low forceps may be indicated to shorten the second stage of labor.

The indications for surgery in rheumatic heart disease will not be expanded upon in this brief article. The most common lesion amenable to surgery during pregnancy is that of mitral stenosis. Mitral insufficiency is technically more difficult and a greater hazard. It is best to perform mitral valvulotomy during the first trimester if the patient has had frequent episodes of pulmonary edema, despite good medical management. If the patient has not had difficulty conceiving, therapeutic abortion with subsequent valvulotomy is an even safer course. After the first trimester, if it becomes necessary to consider the question of valvular repair versus abortion, most investigators, now, would favor the valvulotomy.

Table 2. Cardiac-Obstetric Management to Term, OSMA Exhibit May 12, 1970.

1. Simultaneous cardiac and obstetric observation.
2. Admit before labor, for cardiac evaluation. Prophylactic antibiotics.
3. During labor: work of labor may be severe. Signs of congestive heart failure may appear during second stage.
4. Cesarean section *only for obstetric* indications.
5. Low forceps delivery following full cervical dilatation; shorten second stage.
6. Continue protective cardiac care for 14 days postpartum.

Table 3. Ohio Live Births, Maternal Deaths, and Maternal Deaths Due to Cardiac Disease (from the Ohio Study), 12 Years, 1955-1966.

Total Ohio Live Births, 12 Years	2,652,120
Maternal Deaths (Ohio Study)	886
Maternal Deaths Due to Cardiac Disease	57

Table 4. Analysis of 57 Maternal Deaths Due to Cardiac Disease, Ohio Maternal Mortality Study, 12 Years, 1955-1966.

Valvular Heart Disease (Not Congenital)	30
Congestive Heart Failure (Etiol.?)	11
Congenital Heart Disease (16%)	9
Infarction	3
Endocarditis	2
Rhythm Defects	2
Total	**57**

Table 5. Analysis of Nine Maternal Deaths Due to Congenital Heart Disease, Ohio Maternal Mortality Study, 12 Years, 1955-1966.

I.V. Septal Defect	1
Eisenmenger's Complex	1
Patent Ductus Arteriosus	1
Congenital Aortic Stenosis	1
Anomalous Left Coronary Artery	1
Tetralogy of Fallot	1
Undetermined, presumed congenital (No Autopsy)	3

ONE died immediately postpartum, term delivery
TWO died in second trimester, undelivered
SIX died in third trimester, undelivered

Ohio Statistics

In the Ohio Maternal Mortality Study, during a 12-year period (1955 to 1966) there were *886 maternal deaths* (all causes). Of these, *57 (6.4 percent)* were due to cardiac disease (Table 3). This percentage almost seems negligible until we exclude deaths from hemorrhage, infection, and toxemia, leaving *337* deaths from "other causes," all for the same period. Then, the 57 deaths, out of 337 poses an important comparison! Analyzing the 57 maternal deaths due to cardiac disease (Table 4), it is seen that *nine* (or 16 percent) were associated with *congenital* heart disease. Among these nine, there was quite a variation in the type of defects (Table 5) among the six which were proven by autopsy; the remaining *three* were presumed to have been "congenital" defects, from information obtained in the history and authenticated by the physician's diagnosis on the death certificate.

In conclusion, it is appropriate to reiterate:

1. The cardiac patient, in pregnancy, must be discovered *early* and labelled a "High Risk Patient," preferably *before* she becomes pregnant.

2. She is entitled to the expert "bilateral" care of both a cardiologist and an obstetrician, throughout her gestation, and for a period thereafter.

3. Management of her individual cardiac-obstetric problems will depend upon the skillfull decisions of her two (or more) physicians.

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Indications—Essential hypertension; edema or oscites of congestive heart failure, cirrhosis of the liver and the nephratic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone, particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops.

Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 per cent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For *essential hypertension in adults* the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, *ascites or effusions in adults* initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For *children* the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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References: (1) Sand, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961: (3) Haas, J., and Kay, L.L.: Southwest. Med. 42:30-32, 1961:(4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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Why a Pediatric Convalescence Hospital?

Ronald C. Pinson

Third Year Medical Student, The Ohio State University

THE PRACTICE OF MEDICINE in this generation is coming under the close scrutiny of the public eye. The veil that has shrouded the physician and his practice of medicine through the ages is being lifted and tremendous gaps in health care are pricking the consciences of physician and layman alike. Health care for the aged, rising medical costs, and subpar medical care for low income families are current topics found on many tongues from the middle class citizen who would bear the brunt of the cost, to the impoverished Appalachian in whom illness is a way of life, to the young medical student struggling with loyalities to medical tradition and to his generation which prides itself as being aware of social ills. Granted, the need for pediatric convalescence hospitals is not as sensational or as sensitive as the above named topics, the need exists and should be carefully considered by those responsible for the care of chronically sick children.

The chronically sick child is one requiring hospitalization for 30 to 90 days. Hospitals are not geared to this type of patient care but rather to treating the child with an acute crisis requiring hospital stay of 3 to 14 days. This has serious implications for the chronically sick child. First, in crisis-oriented hospitals with continuous turnover of challenging acute problems, medical staffs may tend to neglect the convalescent patient. Burke recognizes this problem as seen in this terse statement: "The total interest of the nursing and medical staff in most hospitals is greatly diluted in the convalescent child, leading to neglect in many cases."[1] In such circumstances where a child's emotional needs are neglected, even though his medical needs are met, the consequences can be far-reaching. Briggs goes as far as to say that such treatment may result in a misfit: "Thus by treating the physical problem and neglecting the emotional needs of the child we may be condemning such a child to a life as a social misfit who is unable to realize his potential and may require varying periods of institutionalization at a later date."[2] Because of the shortage of hospital beds, the convalescent child may be deprived of an adequate length of time for proper evaluation of his loss of functional capacity. Indeed, in some instances, decisions on long-term rehabilitation therapy are made on inadequate observations in the present crisis-oriented, short-term pediatric hospitals.

The obvious answer to such problems is the creation of pediatric convalescent hospitals. These hospitals would be extended care units especially designed and staffed to treat and evaluate chronically sick children. In such hospitals, both the medical and the psychological needs of the chronically sick child could be provided. It should be emphasized that current pediatric hospitals are limited in their ability to meet the latter need. Green drives this point home with this remark: "The physical structure and medical customs of most

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This student editorial was selected by Dr. Edward V. Turner, Professor of Pediatrics, The Ohio State University College of Medicine, from papers written by third year medical students studying pediatrics at Children's Hospital, Columbus, Ohio.

From the Department of Pediatrics, The Ohio State University College of Medicine.

Reprint requests to Children's Hospital, Columbus, Ohio 43205.

Submitted August 20, 1969.

children's hospitals currently place realistic limits on any program intended to ameliorate the psychologically deleterious effects of hospitalization."[3] If care for chronically sick children is to improve, clearly, plans must be laid for an entirely new concept in children's hospitals.

There are other advantages to having pediatric convalescence hospitals. One is the field of teaching. Medical students, by the nature of medical education, tend to concern themselves with disease and not really to comprehend or to appreciate how the disease is affecting the individual. In a pediatric convalescence hospital the long term psychologic and biologic effects of disease could be observed by students. Concerning this idea Burke comments on the limitations of the present system: "Medical students have little or no opportunity to observe the after effects, biologically or behaviorally, of many illnesses in a brief 4-5 day hospital stay where most of their current hospital training is carried out."[1]

Another important aspect to consider is the unique opportunities for research in the field of chronic disease that long-term convalescence hospitals would provide. For example, asthmatics could be more closely followed to determine the triggering mechanisms in this complex disease.

One problem now confronting hospitals is an acute shortage of beds for children. There are many factors that enter into this problem, but Robinson has shown that pediatric convalescence hospitals could contribute much toward its solution. He has found that chronically sick children, only 3 percent of the total pediatric hospital patients, occupy 20 percent of the hospital beds.[4] A decreased patient load of 3 percent and an increased hospital bed capacity of 20 percent would do much to relieve the current hospital bed shortage.

Still another advantage of such long-term hospitals as proposed is that they would reduce the cost of patient care. In a regional pediatric hospital in Washington, D.C., the per diem rate for the average patient was $70 per day. It has been estimated[1] that the average cost per diem for a patient in a pediatric convalescence hospital would range from $25 to $30. This reduction in cost results from the change in emphasis of a pediatric convalescence hospital. For example, the need for expensive, elaborate emergency equipment now in acute care hospitals would not be present in convalescence hospitals.

Reduced cost of patient care, freeing beds for acute problems in conventional hospitals, and teaching and research advantages are important factors in considering the feasibility of future pediatric convalescence hospitals, but the most compelling reason must be that in such hospitals the chronically sick child would receive the care, attention, and evaluation that he needs and deserves.

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3. Green M, Segar WE: A new design for patient care and pediatric education in a children's hospital: an interim report. *Pediatrics* **28**:825-837, 1961.
4. Robinson GC, et al: A study of the need for alternative types of health care for children in hospitals. *Pediatrics* **43**:866-878, 1969.

Answers to Self-Evaluation Quiz

Page 919 Question 1. (D)

Question 2. (C) or (D)

Question 3. (A)



Professional Activities

Proceedings of The Council...

Meeting of July 18-19, 1970 in Columbus

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, July 18 and July 19, 1970, at the Crown Inns Motor Inn, 888 East Dublin-Granville Road, Columbus, Ohio.

Those present on Saturday, July 18, were: All members of the Council except Dr. P. John Robechek, Cleveland, President-Elect. Others in attendance were: Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. James S. Imboden, Columbus, AMA Field Representative; Dr. John H. Budd, Cleveland, chairman of the Ohio delegation to the AMA; Messrs. Page, Gillen, Clinger, Price and Moore of the OSMA staff. Those present by invitation were: Dr. Robert P. McFarland, Oberlin, Dr. Ward Young, Elyria, and Dr. Paul J. Kopsch, Lorain, representing the Lorain County Medical Society.

Those present on Sunday, July 19, were: All members of the Council except Dr. Robechek. Others in attendance were: Mr. Stichter, Mr. Imboden, Dr. Budd, and Messrs. Page, Gillen, Campbell, Clinger, Price and Moore of the OSMA staff. Present by invitation were: Mr. Arthur Shepard and Mr. Jack Hesler, representing Turner & Shepard, Inc., Columbus; Dr. Homer Anderson, Columbus, chairman of the OSMA Judicial and Professional Relations Committee; and Dr. W. Thomas Washam, Columbus, representing the Ohio State Medical Board.

Reports by President Fulton

Professional Liability Seminar

Dr. Fulton reported on the Professional Liability Seminar, sponsored by the Ohio Osteopathic Association of Physicians and Surgeons and the Ohio Hospital Association and held in Columbus, June 10, 1970. Dr. Fulton attended the seminar for the Ohio State Medical Association.

Organization of State Medical Association Presidents

Dr. Fulton presented a summary of the meeting of the Organization of State Medical Association Presidents, which was held on Saturday, June 20, 1970, prior to the American Medical Association meeting in Chicago.

Fall District Conferences

Dr. Fulton proposed the format for the Fall Councilor District Conferences and obtained Council **approval.**

Minutes Approved

Minutes of meetings held April 18 and 19

and May 15, 1970, were approved by official action.

Reports by Councilors

Councilors reported on organizational activities in their respective districts.

Membership

Membership statistics were discussed by the Executive Director. It was indicated that membership for July 15, 1970 was 9,969, compared to a membership of 10,043 on July 15, 1969.

Hocking Valley Community Hospital

A controversy involving the Hocking Valley Community Hospital in Logan, Ohio was discussed. The Council voted to meet with the Ohio Hospital Association in regard to jointly providing the services of the two associations for binding arbitration in this matter.

Woman's Auxiliary Commended

The Council voted to commend the Woman's Auxiliary to the Ohio State Medical Association for its generous contribution to the American Medical Association Education and Research Foundation and to congratulate the Auxiliary on its award from the American Medical Association as a result of this contribution.

Summit County Constitution and Bylaws

The Council considered proposed changes in the Summit County Constitution and Bylaws to establish osteopathic membership. At the same time, a request was received from the Executive Director for advice with regard to what changes might be needed in the county medical society bylaws to bring them into conformity with the 1970 revisions of the Constitution and Bylaws of the Ohio State Medical Association and to permit osteopathic physicians and surgeons to become active members of the Ohio State Medical Association.

Action on the amendments to the Summit County Constitution and Bylaws was deferred, pending the issuance of "model" county medical society bylaws amendments to effect the conformity with the Ohio State Medical Association Constitution and Bylaws. Other areas to be studied in effecting this conformity are the disciplinary procedures and Sections 7, 8 and 9 of Chapter 11, which include the exculpatory provision, effect of termination of a certificate, and failure to maintain membership in the Ohio State Medical Association. Also to be considered is the new section on eligibility.

American Medical Association

As chairman of the AMA delegation, Dr. Budd reported on the annual meeting of the American Medical Association held June 21-25 in Chicago.

Resolution No. 18

Ohio Resolution No. 18, supporting the recommendations made by the Ad Hoc Committee on the Establishment of a Permanent Long Range Planning and Development Committee, was adopted.

Resolution No. 52

Resolution No. 52, which originated in Stark County as Resolution No. 14-70 at the Ohio State Medical Association annual meeting, requesting the American Medical Association to develop methods of compiling accurate and comparable statistics and to provide factual, concise, truthful rebuttals wherever and whenever false and misleading statistics are used, was adopted.

Resolution No. 53

Resolution No. 53, inspired by Dr. Smith's presidential address, to develop management training courses to utilize the talents and experience of retiring state officers, was referred to the Board of Trustees.

Resolution No. 64

Resolution No. 64, urging opposition to the withdrawal of pharmaceuticals from the market on the basis of recommendations of panels of research and academic personnel alone, and asking utilization of the experience and advice of clinical practitioners, was referred to the Board of Trustees for consideration in the Board's continuing study of this matter.

Increase in AMA Dues

Dr. Budd announced that the delegates voted to increase the AMA dues by $40.

Elections

Dr. George W. Petznick, Cleveland, was renominated and reelected to the Judicial Council of the American Medical Association. Dr. Budd was elected a trustee of the American Medical Association. Dr. Richard L. Meiling, Columbus, was nominated by the President and Chairman of the Ohio delegation for membership on the permanent Committee on Long Range Planning and Development, which was established as a result of resolutions submitted by Ohio's delegation to the American Medical Association.

Student American Medical Association

Drs. McLarnan, Bates, Fishman and Ivins reported on meetings with representatives of the Student American Medical Association chapters at the Ohio State University College of Medicine,

the Medical College of Ohio at Toledo, Western Reserve University School of Medicine, and the University of Cincinnati College of Medicine.

A request that funds, formerly made available to the Ohio State University Chapter for the publication of a newsletter, be used instead for a statewide survey by all four chapters to determine the needs and opportunities for physicians in Ohio and what the Ohio communities have to offer, was discussed. The Council directed that a written plan outlining in detail the methods to be used and estimates of costs be submitted prior to consideration of the request.

With regard to requests for representation of members of the Student American Medical Association on committees of the Ohio State Medical Association, it was the Council's expressed opinion that the Student AMA Chapters be encouraged to approach this activity in steps, beginning at the county medical society level.

Committee Reports

Eye Care

Mr. Clinger presented the minutes of the April 26 meeting of the Committee on Eye Care. The Council postponed action on a recommendation with regard to proposed optical dispensing legislation and approved a meeting with representatives of the Ohio Optometric Association. The remainder of the report was accepted for information.

Private Practice

Dr. Lieber presented the minutes of the June 17 meeting of the Committee on Private Practice. The minutes *were approved* as presented.

Sports Medicine

Mr. Clinger presented the minutes of the meetings of the Committee on Sports Medicine of May 12 and July 2. Both sets of minutes *were approved* as presented.

Family Practice Scholarship

The minutes of the July 8 meeting of the Family Practice Scholarship Subcommittee were presented by Mr. Clinger and *were approved.*

Rural Health

The minutes of the July 8 meeting of the Committee on Rural Health *were approved* as presented by Mr. Clinger.

These minutes had to do with the committee's clinical clerkship in the community medicine program, formerly entitled the senior clerkship in community medicine program. Six recommendations of the committee in connection with the implementation of this project *were approved* by the Council.

Maternal Health

Minutes of the July 12 meeting of the Committee on Maternal Health, presented by Mr. Gillen, *were approved.*

Fee Review

The July 15 meeting of the Council Fee Review Committee was discussed by Dr. Ivins. Four cases were presented for the information of the Council and the recommendations of the committee in each of the four cases *were approved* by the Council.

Auditing and Appropriations

Minutes of the meeting of the Committee on Auditing and Appropriations held Friday, July 17, 1970, were presented by Dr. Schultz, chairman of the committee.

Approval of the minutes included the *approval* of the following:

The establishment of a nonmember subscription price for *The Ohio State Medical Journal* at $5 per year, and a member subscription price at $4.50 per year.

Authorization for the formation of a nonprofit corporation to be known as Medical Advances Institute.

A policy statement with regard to the OSMA Pension Trust Program for the employees, indicating that a previous program of the Association would not be continued under the Ohio State Medical Association aegis.

That funds paid by the American Medical Association for the collection of AMA dues be distributed to county medical societies in the case of all sums over and above $150. In the case of counties where the amount would be under $150, that such funds be distributed to the American Medical Association Education and Research Foundation as before.

Cancer

Minutes of the May 27 meeting of the Ohio Cancer Coordinating Committee, Inc., were presented by Mr. Clinger and *were accepted* for information.

Special Education

Minutes of a meeting of the Joint Advisory Committee on Special Education held on July 15 were presented by Mr. Clinger. The following recommendations of the committee *were approved.*

1. That "checklists" be developed by the OSMA for physicians and by the Ohio Department

of Education for educators to be used for evaluating children being considered for placement in special education programs for learning disabilities.

2. That the committee develop appropriate medical evaluative procedures which should be used in lieu of the present EEG requirement—and that the EEG requirement be dropped.

The remainder of the report *was accepted* for information.

1971 Annual Meeting

The Council instructed the Membership and Planning Committee to study the annual meeting with respect to correlating the cost of the meeting with its value to each member of the Association.

The following recommendations of the Committee on Scientific Work, as contained in the minutes of the July 8 meeting of the committee, were presented by Mr. Campbell and *were approved:*

1. That the theme of the 1971 Annual Meeting in Columbus be "The Physician: Key to Better Health."

2. The schedule of events of the 1971 program.

3. That James L. Henry, M.D. be named chairman of the 1971 social function "OSMA's Night at Scioto Downs" and that a "profit" system be established in connection with the social function and the proceeds be donated to the American Medical Association Education and Research Foundation.

4. That the Council instruct the Committee on Scientific Work to develop specific facts, figures and recommendations concerning the OSMA holding an annual meeting or meetings out of the State of Ohio.

5. That the entire official program not be sent to all members of the Association and that a self-mailer promotion piece be mailed instead.

6. That the OSMA continue to publish, prior to the meeting, a complete summary in *The Ohio State Medical Journal* and that the summary be placed in a prominent position in *The Journal.*

7. That every effort be made to involve and encourage attendance of physicians in all areas of the state.

8. That the Council ask the Membership and Planning Committee to include, in their next survey, questions to the membership to determine exactly what OSMA members want in connection with the annual meeting format and planning.

Followup on 1970 Resolutions

Tenure of Office and Compensation of OSMA President

The President, with the approval of the Council, appointed the following committee to study the tenure of office of the President of the Ohio State Medical Association and to study the matter of what compensation should be provided for the President: Dr. Homer Anderson, Columbus; Dr. James C. McLarnan, Mt. Vernon; and Dr. Robert A. Heilman, Columbus. A tentative reporting date of February, 1971, was established. The matters before the committee were brought before the House of Delegates in the presidential address.

Speaker for the OSMA House of Delegates

Dr. Robert N. Smith, Toledo, reported for the committee assigned to determine whether the OSMA should have a speaker for the House of Delegates. The Council accepted the Committee's recommendation that the establishment of the office *not* be considered.

Student AMA Delegates

In connection with the implementation of **Amended Resolution No. 5-70,** authorizing delegates from the Ohio Chapters of the Student American Medical Association to attend the OSMA House of Delegates, the Council authorized a letter to each Ohio chapter inviting it to elect a delegate and alternate to the 1971 meeting of the Ohio State Medical Association and indicating that expenses would not be provided. Dr. Oscar Clarke ninth district councilor, was appointed by the President to draft clarifying amendments with regard to Resolution 5-70 to be presented at the next meeting of the House of Delegates.

Expulsion of Members Who Do Not Complete Citizenship Within Five Years

Resolution No. 6-70, with regard to the automatic expulsion of OSMA members who do not complete citizenship within a period of five years, was referred to the Department of Medical Economic Research for study.

Out-Patient Coverage by OMI in Office of Physicians in Private Practice

Resolution No. 7-70, with regard to the provision of out-patient coverage by Ohio Medical Indemnity, Inc., was referred to Dr. Robert N. Smith, chairman of the Liaison Committee be-

tween the Council and Ohio Medical Indemnity, Inc.

AMA Committee on Long Range Planning and Development

Amended Resolution No. 15-70 asked for the appointment of a committee to follow up the activities of the AMA Committee on Long Range Planning and Development. The President appointed, with Council's approval, Dr. Richard L. Meiling, Columbus, Chairman; Dr. John H. Budd, Cleveland; and Dr. David Fishman, Cleveland. This committee will be expected to prepare a report prior to the 1971 session of the OSMA House of Delegates.

Establishment of Incorporated Group Practice

Resolution No. 20-70, with regard to the establishment of incorporated group practice, was referred to the Council with instructions that Council report back to the next meeting of the House. The Council referred this matter to the following ad hoc committee appointed by the President with the *approval* of the Council: Dr. Robert E. Howard, Cincinnati, Chairman; Dr. James C. Good, Worthington; Dr. H. William Porterfield, Columbus; and Dr. Sol Maggied, West Jefferson.

Formation of Medical Task Forces on a National Basis

Resolution No. 23-70, concerning the formation of medical task forces on a national basis to be sent into areas where medical need is demonstrated, was not adopted, but the committee recommended that an in depth study be made by the Association to determine the needs for medical care on both a short-term and long-term basis. This recommendation was referred to the ad hoc committee composed of Drs. Howard, Good, Porterfield and Maggied.

State Medical Board

Dr. W. Thomas Washam discussed with the Council the work of the Ohio State Medical Board. He announced the appointment by Dr. Ralph K. Ramsayer, Canton, president of the Board, of a Subcommittee on Continuing Reorganization of the Ohio State Medical Board, as follows: Frederick T. Merchant, M.D., Marion, Chairman; James O. Watson, D.O., Columbus; and W. Thomas Washam, M.D., Columbus. He emphasized to the Council the Board's need for additional space and personnel.

American School Health Association

With regard to a request from the American School Health Association for permission to mail their educational material to OSMA members, the Council *approved* the enclosure of selected American School Health Association literature with the *OSMAgram.*

Placement Service for Osteopaths

The Council granted to the OSMA Placement Service the authority to assist qualified osteopathic physicians and surgeons in locating practice opportunities in Ohio.

Nurse Anesthetists

With regard to a question from the Summit County Medical Society on the hiring of nurse anesthetists, the Council directs to the attention of the Summit County Medical Society section 33, page 47, of the 1969 edition of the AMA Judicial Council's Opinions and Reports which reads as follows:

> "Medicine has always insisted that anesthesia is a medical service, which should be administered by a licensed, trained physician or by another adequately trained person who acts under the direction and supervision of a physician who assumes responsibility for the medical service rendered. A physician properly should present a bill for the services he renders to the patient."

Health Program for Teenagers

Mr. Page reported on the Indiana State Medical Association program for teenagers. His report *was accepted* for information.

Malpractice Suits, Grievance Cases and Public Welfare Cases

The Council reviewed staff reports on malpractice suits in Ohio, grievance cases handled through the Ohio State Medical Association and its Council, and Public Welfare cases reviewed through the official review facilities of the Association.

Pharmacy Practice Act Revisions

Proposed revisions in the Ohio Pharmacy Practice Act, submitted by the Ohio State Pharmaceutical Association, were referred to the Committee on Public Relations for study.

Washington Visitation Project

With regard to the Washington visitation project of the Association, the Council suggested that representatives of the Ohio State Medical Association be selected for specific assignments and that all members of the Council and all

members of the staff would not need to participate in this function.

State Hospital Problems

The medical care situation at the Portsmouth Receiving Hospital was brought to the attention of the Council by Dr. Clarke. This was discussed with general problems of staffing and medical care of patients in all state hospitals and was referred to the Committee on Mental Health for study.

Group Life Insurance

Mr. Arthur Shepard and Mr. Jack Hesler appeared before the Council to discuss suggested improvements in the group life insurance plan sponsored by the Ohio State Medical Association. The following recommendations were approved:

That a change to a cash dividend basis only be made instead of paid-up life insurance.

That a reduction of premium structure be made and dependents' insurance be added.

The changes are to be effective September 1, 1970.

Physicians in Osteopathic Hospitals

In answer to a letter from a Cleveland physician concerning the acceptance of a position in an osteopathic hospital, it was the expression of the Council that there was no objection, providing the members of the staff of the osteopathic hospital practice scientific medicine and abide by ethical principles equivalent to the Principles of Medical Ethics of the American Medical Association.

Date of Next Meeting

The date of the next Council meeting was set for September 19 and 20, with a meeting of the AMA delegates and alternates on September 18.

ATTEST: Hart F. Page
Executive Director

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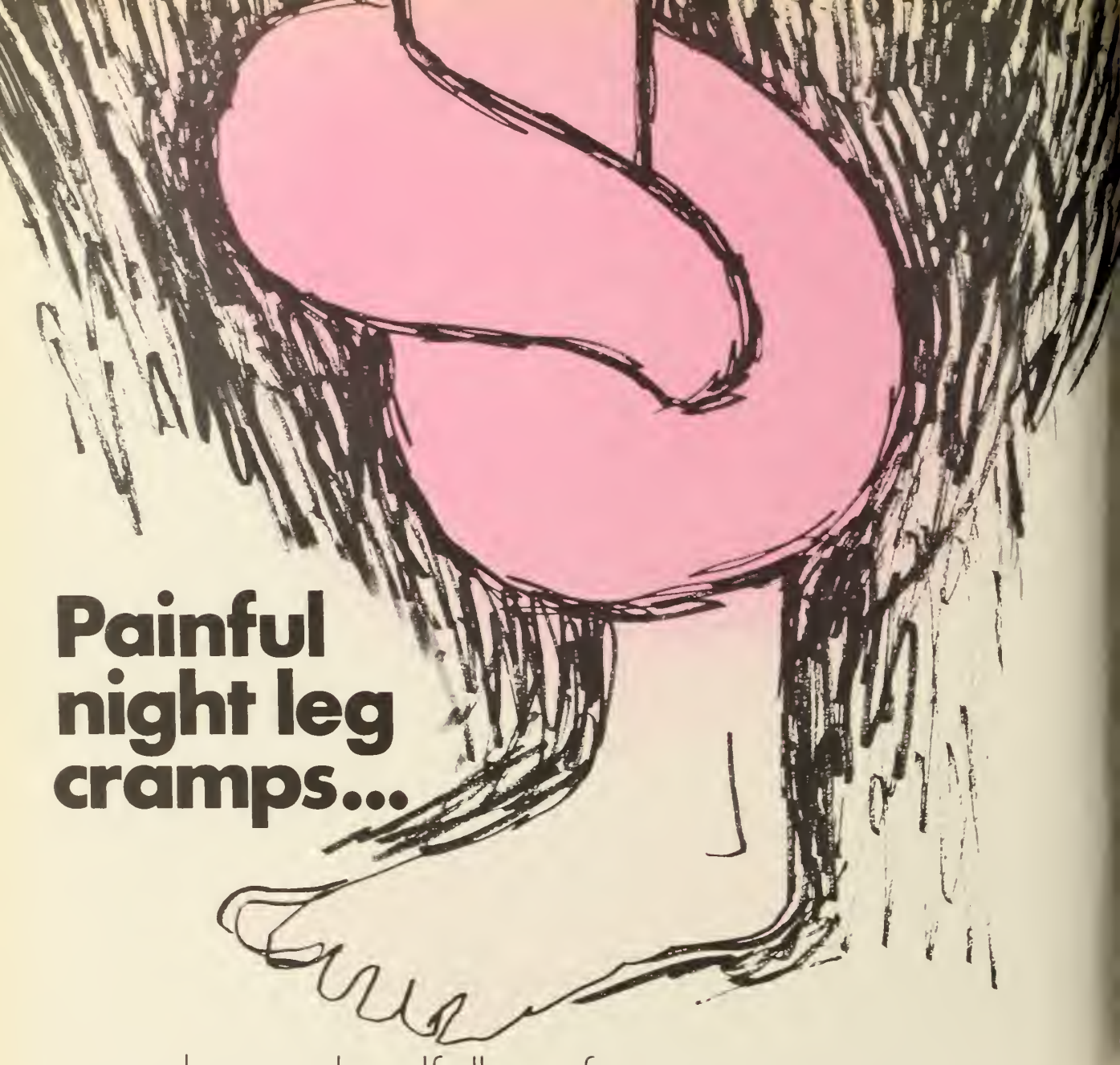
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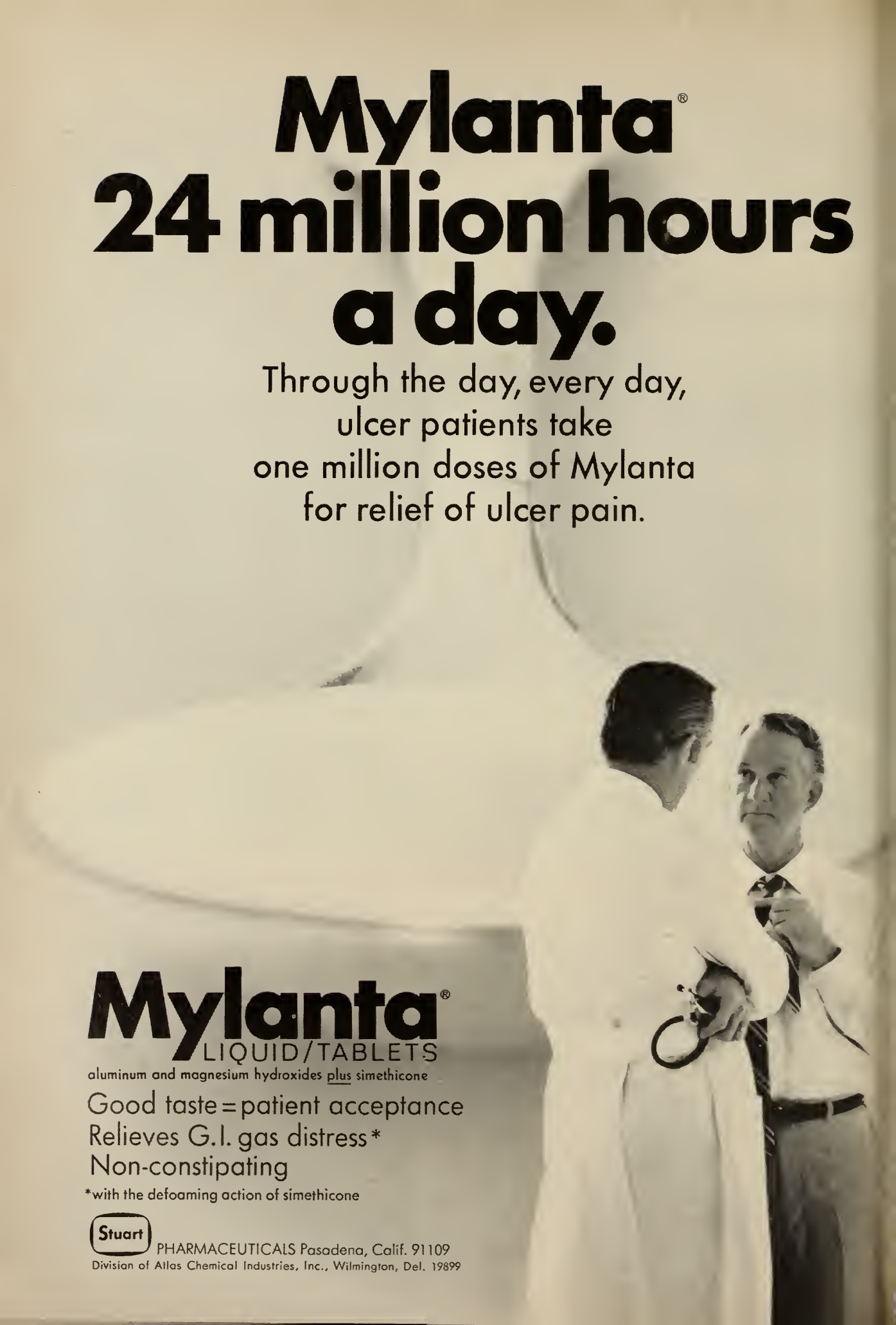
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ON THE OMPAC FRONT

Using Available Channels to Spread OMPAC News

Some physicians have suggested that the Ohio Medical Political Action Committee should issue a newsletter or bulletin on a regular scheduled basis.

This has been discussed by the Board of Directors of OMPAC on numerous occasions. Each time the idea was rejected for the following reasons:

1. It would be an expensive project. At present OMPAC operates with a minimum of staff to keep down expenses to have more "hard dollars" for contributions to candidates. Publication and mailing of a bulletin or newsletter would necessitate enlargement of the staff and increased expenses in the form of wages. Postage costs these days are not peanuts, either.

2. Actually, the primary job of OMPAC is to raise money and distribute it to approved candidates. It depends heavily on the cooperation of the County Medical Societies in its money-raising activities through combined billing at the time medical society dues are collected each fall. These are activities which do not provide news for bulletins or newsletters.

3. Keeping physicians informed on political, governmental and legislative trends of interest to the medical profession is the responsibility and function of the Ohio State Medical Association. Through its committee reports, *The Ohio State Medical Journal,* the *OSMAgram* and special bulletins, the State Association gives its members pertinent and timely information on legislative and government trends and events. A duplication of these efforts would be uneconomical and unnecessary, and, of course, it would not be proper for OMPAC to infringe on the field of the OSMA.

4. OMPAC does try to give the members of the State Association interesting news and comments from time to time in *The Ohio State Medical Journal* and will continue to do so as long as *The Journal* provides space for these reports.

5. After the General Election every other year, OMPAC has followed the practice of issuing a special bulletin or brochure to all members of the Ohio State Medical Association, outlining how OMPAC's funds were distributed to candidates and the won-lost records of candidates receiving OMPAC assistance. This has been general information without the use of names or specific amounts contributed to any candidate. OMPAC will continue to keep physicians advised on its batting averages in the various general elections. Anyone who may wish to see the reports issued after the 1966 and 1968 elections may obtain a copy by writing to OMPAC, Box 5617, Columbus, Ohio 43221.

6. Many physicians complain that they are swamped now with publications, bulletins and newsletters of all kind. One by OMPAC would probably just be another feather in the hat of the law of diminishing returns. OMPAC officials believe its money can be better spent by helping to elect qualified candidates.

7. OMPAC officials do encourage plenty of "jawboning" on the part of those who belong to OMPAC among their nonmember colleagues. While the eyeball-to-eyeball approach is not the most effective way to get OMPAC funds, it can be a very useful procedure in a special drive for contributions. Getting enough persons sufficiently interested to make personal solicitations offers quite a problem in many communities. It takes a spark plug with some organization skill to get the job accomplished. Volunteers will be welcomed by the OMPAC Board.

—*The Ohio Medical Political Action Committee*

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Outstanding Scientific Exhibits at 1970 Annual Meeting

PROMINENT FEATURES of the 1970 OSMA Annual Meeting in Columbus were displayed on the exhibit floor of the Veterans Memorial Building where some 33 scientific exhibits, 18 health education, and 79 technical exhibits were presented on Tuesday, Wednesday, and Thursday of the Annual Meeting week.

Ten exhibits were selected as outstanding by a judging committee and the sponsors were presented certificates of recognition and permanent type plaques to be displayed on the exhibits and afterward kept as mementos. This procedure has been followed for a number of years upon recommendation of the Committee on Scientific work with the approval of The Council.

A summary of exhibits selected to receive such recognition was published in the July issue of *The Journal,* page 720. Following is additional information, with illustrations, of four outstanding exhibits. Watch for more on the selected exhibits in a future issue.

Heart Surgery Exhibit Wins Gold Award

The Gold Award in the field of Original Investigation was presented to sponsors of the exhibit entitled "Venous Autograph Reconstruction for Segmental Coronary Disease." The sponsoring team from the Cleveland Clinic consisted of the following physicians: Rene G. Favaloro, M. D., Donald B. Effler, M. D., Laurence K. Groves, M. D., F. Mason Sones, M. D., Earl K. Shirey, M. D., William C. Sheldon, M. D., Mehdi Razavi, M. D., and Robert A. Quint, M. D.

The exhibit demonstrated experience of team members at the Cleveland Clinic with nearly 500 direct surgical procedures for coronary artery disease. Advantages of the technique were demonstrated and tabulation of results were posted. Pre- and postoperative angiographies were presented and the TV monitor showed results in motion picture. Heart models further graphically illustrated the different surgical techniques involved.

It is significant that virtually the same team presented a similar exhibit at the 1969 OSMA Annual Meeting and received the Gold Award in Original Investigation at that time also.

Exhibit on Hand Examination Presented Silver Award

Sponsors of the exhibit entitled "A Method of Examining Tendons and Nerves in the Hand" were presented the Silver Award in Teaching. Members of the Ohio State University Hand Clinic team are Robert J. Duran, M. D., Robert G. Houser, M. D., and Richard Mattison, M. D.

This exhibit presented a method of examination which the sponsors have found reduces the possibility of missing tendon and nerve injuries. The specific examination of tendons and nerves of the hand were demonstrated by photographs and cutaway anatomic drawings. Visual diagnoses were illustrated in photographs and a movie demonstrated the sequence of examination.

Cystic Fibrosis Exhibit Wins Bronze Award

The Bronze Award in Teaching was presented to sponsors of the exhibit, "Cystic Fibrosis — an Obstructive Pulmonary Disease," sponsored by the following team from Case Western Reserve University School of Medicine: Bernard Boxerbaum, M. D., Carl F. Doershuk, M. D., LeRoy W. Matthews, M. D., Robert C. Stern, M. D., and Susan Pittman, M. D.

As background for the presentation, sponsors pointed out that cystic fibrosis is a generalized disease of children involving the exocrine glands. Of the mortality associated with cystic fibrosis, 90 percent results from the pulmonary involvement, which initially consists of obstruction of small bronchi and bronchioles with mucus secretions.

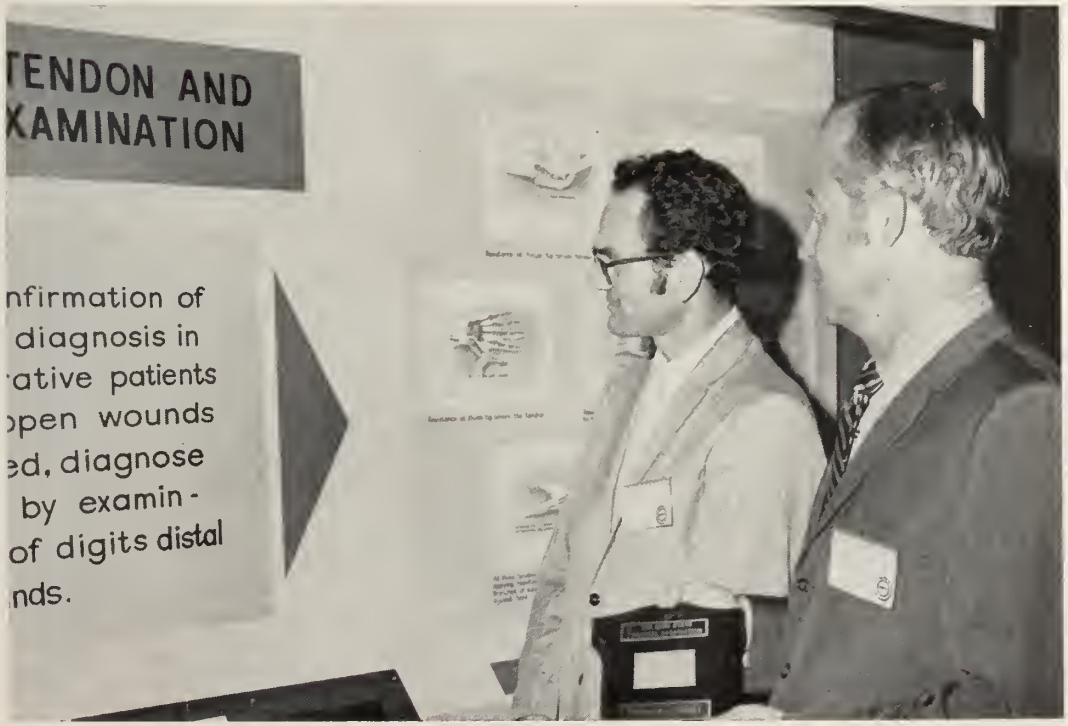
The manifestations of cystic fibrosis and signs of recognition were presented, particularly the pulmonary obstruction and infection aspects. Illustrations showed both patients and chest x-rays. The exhibit included general management principles and the use of inhalation therapy (mist tent therapy, intermittent aerosol therapy) and physical therapy measures.

The bacterial etiology of secondary infection that causes the irreversible lung damage and death were reviewed. This included the Staphylococcus

Outstanding Exhibits Recognized



Dr. Mehdi Razavi, one of the sponsors, holds the Gold Award in Original Investigation just presented to him by Dr. Oscar Clarke, right, member of the Exhibit Judging Committee, for the exhibit "Venous Autograph Reconstruction for Segmental Coronary Disease." On the left is Dr. Fred A. Heupler, member of the team of physicians who manned the exhibit.



Dr. Robert G. Houser, left, one of the sponsors, discusses a feature of the exhibit, "A Method of Examining Tendons and Nerves in the Hand," with OSMA 1969-1970 President Robert N. Smith. Dr. Smith holds the Silver Award in Teaching plaque, presented to sponsors of the exhibit.

Outstanding Exhibits Recognized



Dr. Bernard Boxerbaum, left, and Dr. Carl F. Doershuk, two of the sponsors, are congratulated by OSMA 1969-1970 President Robert N. Smith as he presents them the Bronze Award in Teaching for the exhibit, "Cystic Fibrosis — an Obstructive Pulmonary Disease."



Dr. H. William Porterfield, Columbus, one of the sponsors of the exhibit, "Four Years of Experience in Out-Patient Office Surgery," receives a Special Award from Dr. Oscar Clarke, member of the Exhibit Judging Committee. Adding a measure of family pride to the occasion are two of Dr. Porterfield's children, Todd and Wendy.

aureus and Pseudomonas aeruginosa organisms. The appropriate use of culture media to detect these organisms was indicated.

The exhibit pointed out that the selection and use of appropriate antibiotics in the control of pulmonary infection is an important component of the therapy of this disease, and reviewed the currently available antibiotics. This included the results of a study of a new semisynethetic penicillin which can be useful in the therapy of Pseudomonas pulmonary infections of this disease. The study was carried out on 41 hospitalized patients with cystic fibrosis. Antibiotics were used in a controlled fashion, and clinical, bacteriological, chemical, pulmonary function and chest x-ray results before and after therapy were used to complete the evaluation.

Out-Patient Office Surgery Exhibit — Special Award

A Special Award was presented to the exhibit entitled "Four Years Experience in Out-Patient Office Surgery" sponsored by John C. Trabue, M. D., John L. Terry, M. D., H. William Porterfield, M. D., and Eugene R. Perrin, M. D., A Columbus team specializing in plastic surgery.

This exhibit reviewed nearly 4,000 operative procedures performed on an out-patient basis in the office. The various procedures were categorized by type. The techniques for both local and general anesthesia were presented with a review of results and complications. Special emphasis was placed on the safety of out-patient general anesthesia.

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Highlights in Ohio Welfare

Organization and Functions of the Ohio Department of Public Welfare

NECESSARY TO AN UNDERSTANDING of the Ohio Department of Public Welfare is a knowledge of its function and how it is organized to fulfill that function.

The Ohio Department of Public Welfare is an administrative branch of state government which by statute has been made responsible for the supervision of county welfare departments — which, in turn, are directly responsible for providing care for indigent people and for certain rehabilitative services. Quoting from Ohio law, the State Welfare Department, through its county counterparts, is responsible for "the furnishing of aid, support, service, or care to needy persons at public expense, including medical care as may be defined by law; and child welfare services . . ."

Thus welfare is an important function of government, and is accomplished by the administration of eleven welfare programs: Aid for the Aged; Aid to the Blind; Aid to the Permanently and Totally Disabled; Aid to Dependent Children; General Relief; Children Services; Crippled Children's Services; Work Incentive Program; Commodity Distribution and Food Stamp Program; Vocational Rehabilitation for the Blind*; and Medical Assistance Program (Medicaid).

Total responsibility for the operation of the Department lies with the State Welfare Director, who is appointed by and serves at the pleasure of the Governor. The Director is a member of the Governor's Cabinet.

In order to bring administration closer to the county welfare units, five Deputy State Welfare Directors serve as counterparts of the Director in as many administrative districts, located strategically throughout the state.

Actual responsibility for administering aid to the poor lies with the county welfare departments with close supervision provided by the State Department — supervision accomplished through the five District Offices.

In order to provide more efficient supportive services — policy making and accounting functions — to the counties, via the District Offices, the State Welfare Department was reorganized six years ago into three divisions and two bureaus, the chiefs of which report directly to the State Welfare Director. They are: Division of Welfare Services; Division of Administrative Services; Division of Medical Assistance; Bureau of Services for the Blind*: and. Bureau of Crippled Children's Services.

Thus, the Division of Medical Assistance is one of five supportive services included in the organization of the Ohio Department of Public Welfare. Members of the medical profession will be interested in a detailed description of the Division of Medical Assistance which is planned for a future issue of this journal.

*The functions of the Bureau of Services for the Blind, including Vocational Rehabilitation for the Blind, will be transferred to the Rehabilitation Services Commission, effective 10/1/70.

Information in this column was furnished to *The Journal* by personnel of the Ohio Department of Public Welfare.

Register Now for Heart Program in Atlantic City

Form's to register for the 43rd annual Scientific Sessions of the American Heart Association may be obtained through the Assoication's National Office or from local Heart Associations.

The meeting is being held from Thursday morning, November 12 through Sunday noon, November 15 in Convention Hall, Atlantic City, N.J. Seven programs on Clinical Cardiology and concurrent sessions on various phases of cardiovascular research and medicine will be presented. In addition, the meeting will feature lectures, panels, symposia and the screening of recently produced cardiovascular films.

* * *

AHA's Council on Arteriosclerosis will hold its 1970 annual scientific meeting on Tuesday, November 10 and Wednesday November 11 in Howard Johnson's Motor Lodge, Atlantic City, N.J., immediately preceding the Heart Association's Scientific Sessions in that city. The Council sessions are open to all and members and nonmembers are invited to attend.

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Announcement date for most cars is about October 1. Lease deliveries are anticipated to start shortly after.

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Investment Prognosis

By Frank Van Holte, Columbus

LIKE A BREAK in the clouds after a thunderstorm, we now see signs that the business slowdown seems to have bottomed out. At least that's the concensus of most of the market experts. The almost 27 million stockholders in America are ready for some sunshine after the stormy declines of the past year. The second quarter profits were better than expected. Corporations are cutting their costs and eliminating luxuries, and they are preparing new expense budgets. These steps will provide a new foundation for profit margins when business improves.

Of course, the road to recovery will not be without some detours. The Penn Central shock still is felt throughout the country; inflation is still with us, and some industries still face the prospects of prolonged strikes. But the air is clean after the storm and it is now a time of hope and opportunity. In fact, it appears that the hunting season has arrived early this year. You do not have to wait until the late fall or early winter months to experience the thrill of good hunting, but the hunt this time is for stock bargains which can be eminently more rewarding than any other kind of hunt. I dislike the word bargain because it frequently implies that the objects for sale at a bargain are second rate knicknacks. But how else can you describe undervalued stocks more effectively than to call them bargains?

How do we proceed to find these bargains? Unfortunately, many investors think in terms of price and too few think in terms of value. If your broker tells you a stock is a bargain because it is low in price, he may be talking through his fedora. And we should not limit our hunting to only blue chips. Many times blue chips have left investors singing the blues. If you had purchased U.S. Steel in 1959, you could have paid as high as $108 per share and this blue chip is selling in the 30's today. The key to good hunting is to look for growth stocks, but I suppose that word is overused and we might be gun-shy of growth stocks, and that would be disastrous on a hunt.

I would suggest that you direct your hunt to stocks which have demonstrable prospects for growth in earnings. Here are a few suggestions:

1. Approximately 25 percent of the population is between the ages of 15 and 30. This age group buys 40 percent of the clothing sold in the country. It is estimated that college students spend over $45 billion annually on such things as wigs, clothes, travel, records and cosmetics. Would you believe that 25 percent of the teenagers have charge plates in their own names. Companies offering quality merchandise to this age group are pretty good growth prospects, it seems to me.

2. The advancement of medicine is certainly permitting people to live a longer life, and the average retirement age is becoming lower and lower. Social Security benefits will surely increase from time to time. Isn't it likely that companies involved with health progress or fields of leisure offer growth opportunities?

3. How about companies researching and solving the desalination of sea water, or the development of automated highways and air traffic control systems? And of course, the pollution problem offers excellent investment opportunities.

Don't these few suggestions whet your interest in a hunting expedition? If you agree that these fields offer growth opportunities, then you have to "bag" the best buy in each field and that is what makes the hunt interesting and stimulating. Incidentally, I suggest you take along an informed broker to act as a guide on your hunt.

American business has succumbed to hyper-diversification. The big corporations (about 100 dominate American manufacturing, making a third of the sales and capturing about half of the profits) are getting even larger through mergers and investment of their earnings. These giant enterprises are sprawling out across the economic landscape, extending their operations throughout the world and plunging into unrelated product fields. It remains to be proven as to whether this trend is a sign of health or disease.

This monthly feature is written exclusively for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.



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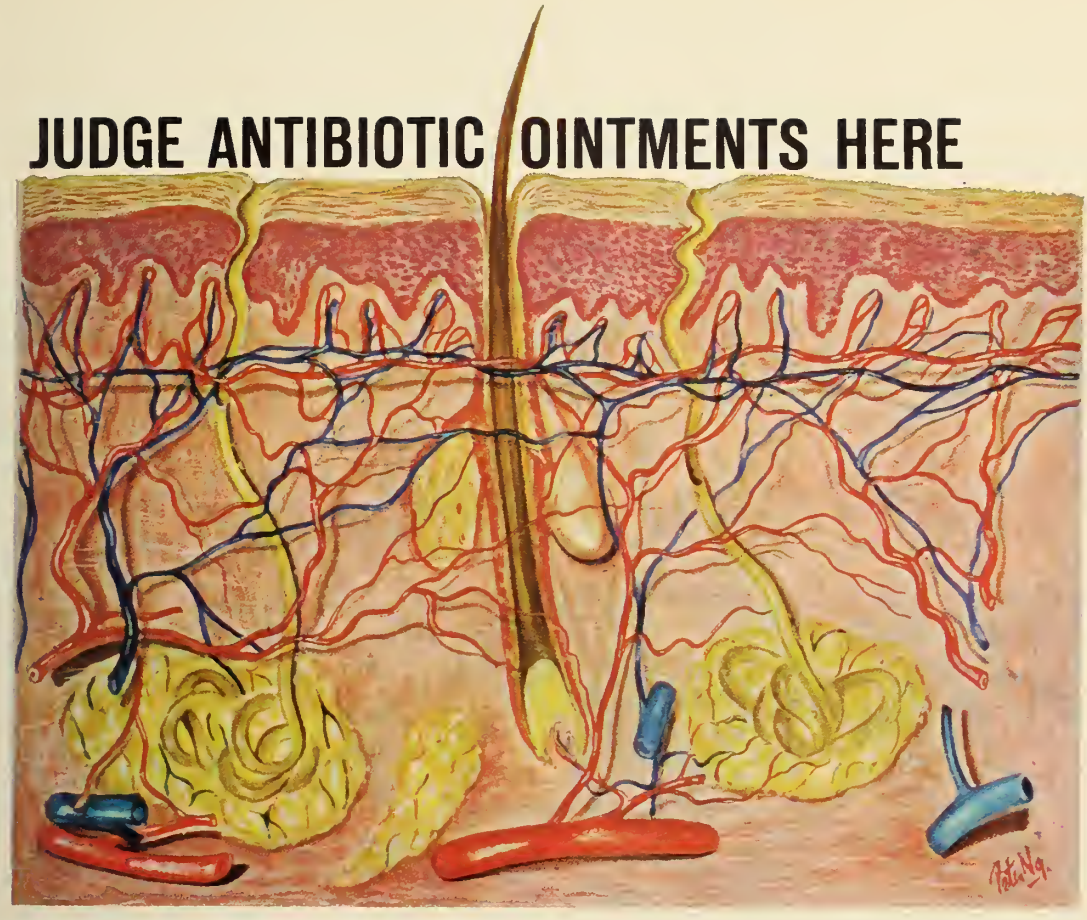
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NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

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KEEPING UP:

Continuing Education Opportunities for Physicians in Ohio

September

Electrophysiology of Arrhythmias — Youngstown Hospital Association, September 14; Dr. W. H. Bunn, Jr., and Dr. S. A. Khuddus.

Tests in Ventilatory Function — Trumbull Memorial Hospital, Warren, luncheon program, September 22; David Gillespie, M.D., head, Pulmonary Unit, Cleveland Metropolitan General Hospital, and assistant professor of medicine, Case Western Reserve University.

Postgraduate Continuing Medical Education Program — Akron City Hospital, 525 E. Market Street, Akron; September 23.

Fifth Contact Lens Seminar — Department of Ophthalmology, Ohio State University College of Medicine, September 24-26; registration open to ophthalmologists, members of the Contact Lens Society of America, members of the Guild of Prescription Opticians, and technicians recommended by ophthalmologists.

Eleventh Annual Pediatric Postgraduate Conference sponsored by OSU College of Medicine, Department of Pediatrics, and the Columbus Children's Hospital, September 24-25; Contact Center for Continuing Medical Education, OSU College of Medicine, 320 W. Tenth Ave., Columbus 43210.

Ohio Chapter, American College of Surgeons, Neil House Motor Hotel, Columbus, September 25-26; Charles G. Livingood, M.D., Secretary, 211 St. Main Street, Dayton 45402.

Diagnostic Techniques in Coronary Artery Disease — Youngstown Hospital Association; September 28; Dr. A. V. Whittaker and Dr. M. Bhatti.

October

Brain Tumor Symposium, Ohio State University College of Medicine, October 5-6; recent advances in tissue culture, biochemistry and chemotherapy will be stressed. Contact W. George Bingham, Jr., M.D., program chairman, Division of Neurological Surgery, 410 West Tenth Avenue, Columbus 43210.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Symposium on the Pancreas, Ohio State University College of Medicine in cooperation with the Central Ohio Diabetes Association; OSU Centennial event; October 6-7. Contact Center for Continuing Medical Education, 320 West Tenth Avenue, Columbus 43210.

Microcirculation of the Heart and Lungs — At St. Vincent Charity Hospital, Cleveland, October 5-7; sponsored by the American College of Cardiology.

Survey of Surgically Remediable Cardiac Lesions — Youngstown Hospital Association; October 12; Dr. J. J. Turner and Dr. S. S. Guleria.

American Institute of Ultrasound in Medicine, 15th annual meeting, Sheraton-Cleveland Hotel, Cleveland, October 12-15; program chairman, Adnan Sokollu, Sc. D., Office of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

Cleveland Course in Pulmonary Disease, Second Annual, St. Luke's Hospital, Cleveland, October 14-15; sponsored by Case Western Reserve University, the Tuberculosis and Respiratory Disease Association of Cleveland, the Ohio TB and Health Association, and the American Thoracic Society. Write Department of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

A Day of Cardiology — Ohio State University College of Medicine, Columbus; October 16, beginning at 9:00 a.m.; contact Arnold M. Weissler, M.D., Department of Medicine, 410 W. Tenth Avenue, Columbus 43210.

(Continued on Next Page)

Current Therapy — Seminar sponsored by the Scioto County Medical Society and the Portsmouth Academy of General Practice, 705 Court Street, Portsmouth, 1:00 p.m., Thursday, October 22; contact Mr. Lowell E. Thompson, Executive Secretary, 1805 27th Street, Portsmouth 45662.

GI Bleeding — At Good Samaritan Hospital, Cincinnati; sponsored by the University of Cincinnati College of Medicine and CONMED: October 22.

A and B Blockers — A and B Stimulators (Pharmacology Series) — Youngstown Hospital Association: October 26; Dr. W. H. Bunn, Jr., and Dr. G. A. Dewan.

Anatominical Aspects of Chronic Respiratory Disease with Clinical Pathological Correlations — Trumbull Memorial Hospital, Warren, luncheon program, October 27; Jerome Kleinerman, M.D., head, Department of Pathology Research and Clinical Pathology, St. Luke's Hospital, Cleveland, and associate clinical professor of pathology, Case Western Reserve University.

Current Practices in the Care of the Newborn — Sponsored by the University of Cincinnati College of Medicine and CONMED, at the Childrens Hospital, Elland Avenue, Cincinnati: October 28.

Convocation on Medicine and Theology — Netherland Hilton Hotel, Cincinnati, October 29, 9:00 a.m. to 4:00 p.m.; sponsored by West Ohio Conference for Clergy and Physicians; contact the Rev. Bruce McClure, Bethesda Hospital, Oak and Reading Road, Cincinnati 45219.

Introductory Course in Nuclear Medicine for Physicians — Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124: contact for dates.

November

Hematology Seminar — Veterans Administration Center, 4100 W. Third Street, Dayton, 8:00 a.m. to 4:30 p.m., November 4. Contact R. G. Belliard, M.D., Chief, Hematology Section, at the center.

Testing Skill Workshop — At the Christopher Inn, Columbus, November 1; sponsored by the Ohio Academy of General Practice.

Ob-Gyn Conference — Sponsored by Ohio State University College of Medicine at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, November 4.

Isotopes in Clinical Medicine (Pharmacology Series) — Youngstown Hospital Association; November 9; Dr. H. N. Bennett and Dr. P. Javean.

Eye Conference — Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus: November 9-10; for specialists.

New Horizons in Reproductive Physiology and Pathology — St. Ann Hospital, 2475 East Blvd., Cleveland 44120, November 11.

Diagnostic Procedures in Gastroenterology — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106: November 11-12.

Neurology Conference — Sponsored by Ohio State University College of Medicine, at OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, November 20.

Chemotherapy in the Patient with Incurable Cancer (Pharmacology Series) — Youngstown Hospital Association: November 23: Dr. W. D. Loeser and Dr. M. Kuangparichat.

Inappropriate Breathlessness - Dyspnea — Trumbell Memorial Hospital, Warren, luncheon program, November 24; George W. Wright, M.D., head, Department of Medical Research, St. Luke's Hospital, Cleveland, and associate clinical professor of medicine, Case Western Reserve University.

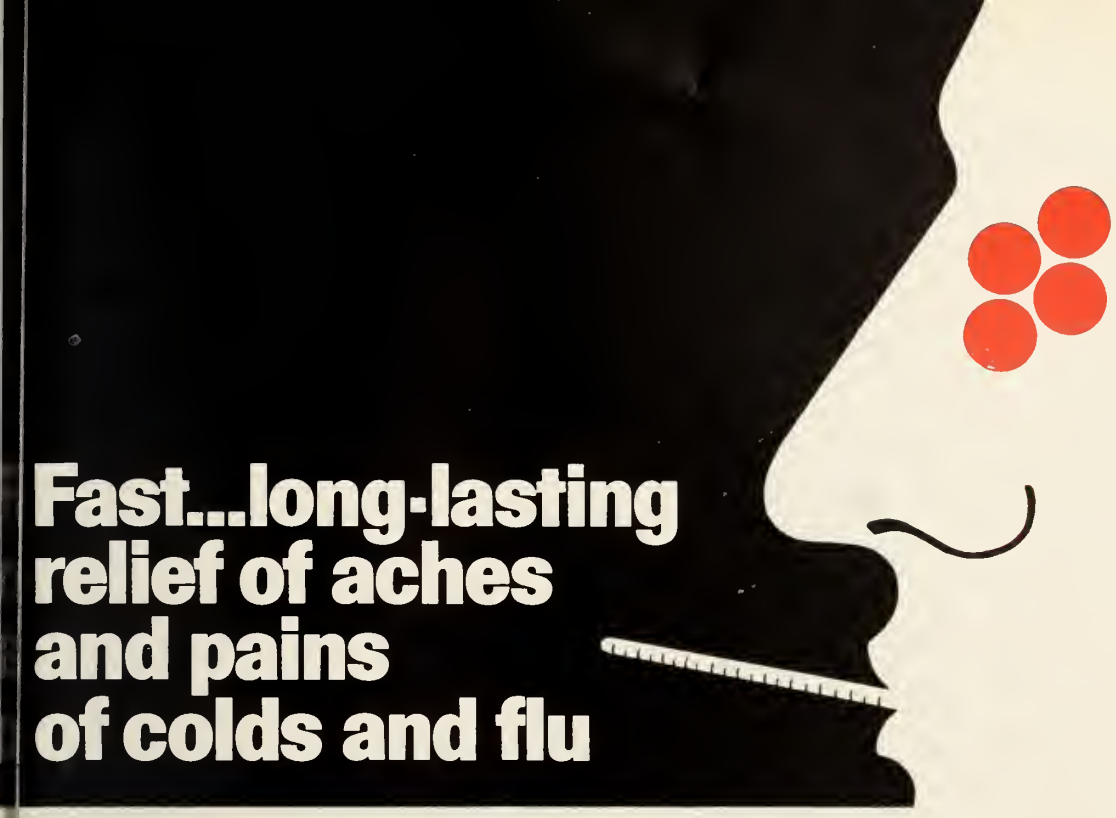
December

Ocular Surgery, Glaucoma and External Disease — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland; December 9-10.

Spinal Cord Injuries Conference — Ohio State University College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, December 10.

Electrolyte and Fluid Balance — At Jewish Hospital, Cincinnati; sponsored by the University of Cincinnati College of Medicine and CONMED: December 10.

New Antibiotics — Gentamycin, Carbentocillin and Others (Pharmacology Series) — Youngstown Hospital Association; December 14: Dr. G. A. Butcher and Dr. J. Conti.



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Obituaries

John Beverly Anderson, Sr., M.D., Cleveland; State University of New York at Buffalo School of Medicine, 1929; aged 67; died July 9; member of the Ohio State Medical Association, the Aerospace Medical Association, American Geriatrics Society, and the American Society of Internal Medicine; practitioner in Cleveland, specializing in internal medicine; a flying physician and member of the Quiet Birdmen and the Silver Wings fraternity; during world War II flight surgeon with the Marine Air Wing; survived by his widow and two sons, Scott and Dr. John B., Jr.

Maximino R. Alcancia, M.D., Cleveland; College of Medicine of Manila Central University, 1951; aged 48; died July 12; first came to the Cleveland area in 1955; recently associated with the Parma Community General Hospital where he specialized in anesthesiology; survived by his widow, two sons, and two daughters.

Norman Evan Basinger, M.D., Elyria; Hahnemann Medical College, Philadelphia, 1938; aged 59; died July 25; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Obstetricians and Gynecologists, and of the American College of Surgeons; diplomate of the American Board of Obstetrics and Gynecology; resident of Elyria for most of his life and practitioner there for about 25 years, specializing in obstetrics and gynecology; veteran of World War II; member of the Congregational Church, the Elks Lodge; survived by his widow, a son, a daughter, and a brother.

Laura DaSef, M.D., Akron; Western Reserve University School of Medicine, 1927; aged 76; died July 26; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Obstetricians and Gynecologists; diplomate of the American Board of Obstetrics and Gynecology; practitioner in the Akron-Barberton area for some 34 years before her retirement; member of the Akron Woman's City Club and the Episcopal Church; survived by a sister.

Oliver William Hosterman, M.D., Columbus; Harvard Medical School, 1933; aged 63; died July 11; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Pediatrics; diplomate of the American Board of Pediatrics; a specialist in pediatrics, associated with Ross Laboratories for the past 13 years; survived by his widow and three sons.

Carl Kaplan, M.D., Canton; Pritzker School of Medicine of the University of Chicago, 1956; aged 38; died June 13; completed residency in urology in the Mayo Graduate School of Medicine in 1963, and practiced at Syosset, Long Island, N. Y., before moving to Canton in 1969; member of the staff of Aultman Hospital.

Bruce Rodger Marshall, M.D., Cleveland; Western Reserve University School of Medicine, 1947; aged 46; died July 22; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; diplomate of the American Board of Otolaryngology; practitioner in the Cleveland area since the early 1960's, specializing in otolaryngology; veteran of World War II and the Korean Conflict; survived by his widow.

Melvin Paul McKinley, M.D., Miami, Florida; Western Reserve University School of Medicine, 1926; aged 77; died June 30; member of the Ohio State Medical Association and the American Medical Association; chief orthopaedic surgeon for the Cleveland Veterans Administration Hospital until his retirement in 1962; private practitioner in Cleveland before World War II and flight surgeon for the Army Air Corps during the war; also veteran of World War I; member of the Masonic Lodge, and Sons of the American Revolution; survived by his widow, two daughters, and a son.

Florian Aloysius Majewski, M.D., Toledo; St. Louis University School of Medicine, 1927; aged 67; died June 14; member of the Ohio State Medical Association; lifelong resident of Toledo and practitioner there for 42 years; member of the Catholic Church, the Catholic Order of Foresters, and the Holy Name Society; survived by his widow, two daughters, and two sons.

Frank Ludwig Moore, M.D., Fremont; University of Michigan Medical School, 1910; aged 84; died June 28; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; native and lifelong resident of Fremont with 54 years of practice there as physician and

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surgeon; leader in community affairs; one of the founders of the local hospital, the Rotary Club; member of the board of education, local library association and county historical society, the Presbyterian Church, and other organizations; survived by his widow, a daughter, and a son, Dr. Leon H. Moore, of Fremont.

Anton William Oelgoetz, M.D., Columbus; Ohio State University College of Medicine, 1917; aged 77; died July 21; recent member of the Ohio State Medical Association and the American Medical Association; member of the American Academy of General Practice; practitioner in Columbus for 54 years; member of the Methodist Church; veteran of World War I; survived by his widow, a daughter, a sister, and a brother.

Roswell Edward Raitz, M.D., Cincinnati; University of Cincinnati College of Medicine, 1924; aged 72; died July 20; former member of the Ohio State Medical Association; practitioner of long standing in the Greater Cincinnati area before his retirement in 1964; veteran of World War II, during which he served overseas with the Army Medical Corps; survived by his widow and a daughter.

George Morgan Reinhart, M.D., Toledo; Starling Medical College, Columbus, 1896; aged 95; died June 25; member of the Ohio State Medical Association and the American Medical Association; practitioner in Toledo from 1904 to 1958, specializing in proctology; member of the Congregational Church and a 32nd Degree Mason; survived by a daughter.

Paul Elmer Rex, M.D., Pineville, La.; Western Reserve University School of Medicine, 1931; aged 66; died July 12; former member of the Ohio State Medical Association; practiced in Rockford, Ohio, during the early 1930's; associated for many years with the Veterans Administration; veteran of World War II; survived by his widow, a sister, and a brother.

Hubert Emerson Shafer, M.D., Middlefield; Ohio State University College of Medicine, 1925; aged 75; died July 12; member of the Ohio State Medical Association and the American Medical Association; practitioner of long standing in the Middlefield area; 32nd Degree Mason, honored by the Chamber of Commerce for his dedication to the community; survived by his widow, a daughter, a son, and two brothers.

George Peter Sorvas, M.D., Dellroy; Hahnemann Medical College of Philadelphia, 1937; aged 57; died July 2; former member of the Ohio State Medical Association; practiced in the Bowerston area of Carroll County from 1962 to 1969; veteran of World War II; member of the Masonic Lodge. Among survivors are his widow, two daughters, a son, and his mother.

Robert Sayre Stockton, M.D., Chesterland; State University of New York at Buffalo School of Medicine, 1940; aged 54; died July 2; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Surgery; practitioner of long standing in Cleveland, specializing in surgery; trustee of the Musical Arts Association, the

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Northern Ohio Opera Association, Cleveland Ballet Guild, and other organizations; survived by his widow, four daughters, his mother, and a brother.

Laimons Emils Vanags, M.D., Butler, Pa.; University of Leiden, the Netherlands, 1951; aged 49; died July 17; former member of the Ohio State Medical Association and recently a member of the Pennsylvania Medical Society; member of the American Medical Association; while in Ohio practiced in Lake County and for a time was associated with the Veterans Administration.

Claude Damon Waltz, M.D., San Diego, Calif.; Ohio State University College of Medicine, 1913; aged 79; died July 11; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons; practitioner for 50 years before his retirement in 1963; Cleveland surgeon who helped to organize the Academy of Medicine of Cleveland and served as one of its officers, as a member of its council, and on numerous committees; interested in a number of Cleveland projects, such as the Booth Memorial Home, the Salvation Army service, etc. Dr. Robert C. Waltz, also of the Cleveland area, is a son; also surviving are his widow, two other sons, two daughters, a brother, and a sister.

Alfred Edwin Weisz, M.D., Los Angeles, Calif.; Case Western Reserve University School of Medicine, 1963; aged 36; died July 23; specialist in psychiatry; survived by his widow, two daughters, a son, and a sister.

Giles Wolverton, M.D., Greenville; Jefferson Medical College of Philadelphia, 1931; aged 68; died July 13; member of the Ohio State Medical Association, the American Medical Association, and the American Thoracic Society; Fellow of the American College of Chest Physicians; practitioner in Dayton from 1933 to 1960; became health commissioner of Preble and Darke Counties in 1960; member of the Episcopal Church, the Rotary Club and other local organizations; survived by his widow, three sons, and a sister.

"Endoscopic Techniques in Gynecology and Infertility" is the title of a film recommended for showing to gynecologists and obstetricians, general practitioners, and ob-gyn residents and interns. It is available through Wyeth sales representatives for showing to physicians in private practice and hospitals and at medical society meetings. The film runs 27 minutes, is 16-mm., full color with optical sound, one reel. Prints can also be obtained on loan from the Wyeth Film Library, Box 8299, Philadelphia, Pa. 19101.

"Current Therapy" Seminar Portsmouth, October 22

The Scioto County Medical Society in cooperation with the Portsmouth Academy of General Practice is presenting its First Annual Postgraduate Medical Seminar on Thursday, October 22 beginning at 1:00 p.m. The theme is "Current Therapy" and the meeting place is the American Legion Hall, 705 Court Street, Portsmouth. American Academy of General Practice Credit has been applied for. All physicians, especially those in surrounding counties of Ohio and Kentucky, are invited.

Officers of the Scioto County Medical Society who helped plan this first in a series of seminars are Dr. Joseph T. Gohmann, president; Dr. Jerome R. Sheets, vice-president and seminar chairman; Dr. John A. Walker, secretary-treasurer and seminar cochairman; Dr. S. W. Miller and Dr. R. Villarreal, committee members; and Dr. Sol Asch, who will be seminar moderator.

Officers of the Portsmouth Academy of General Practice are Dr. Henry Rogowski, president, and Dr. William E. Daehler, secretary.

Contact may be made with Mr. Lowell E. Thompson, executive secretary, 1805 27th Street, Portsmouth 45662.

Faculty

Dr. Manuel Tzagournis, associate professor of Medicine, Ohio State University College of Medicine, Columbus.

Dr. Charles F. Wooley, associate professor of medicine and director of the Cardiac Catherization Laboratory, OSU.

Dr. George W. Paulson, associate professor of medicine (neurology), OSU.

Dr. Arthur T. Evans, professor of urology, University of Cincinnati College of Medicine.

Dr. Adolph Haas, clinical associate professor, Department of Psychiatry, OSU.

Program

Treatment of Problems in Diabetes — Dr. Tzagournis

Use of Transvenous Pacemakers — Dr. Wooley

Use of L-Dopa in Parkinsonism — Dr. Paulson

Clinical Therapy of Sex Problems — Dr. Evans

Informal Discussion

Social Hour and Dinner

Psychoemotional Sex Problems — Dr. Haas

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati, Ohio 45243

THE NAME'S BEEN UP-DATED but the goal is the same — this annual gathering of county and state officers and chairmen is designed for auxiliary leaders to get acquainted and to exchange ideas. Come to Columbus on Tuesday, September 29 for a full day of learning what auxiliary is all about. The conference is being held at the Crown Inns Motor Inn, 888 E. Granville Road (Route 161 near I-71, in North Columbus). Ann Wiessinger, our president-elect, has sent details of the program to all counties but in case you were missed, here is the program you can't afford to miss!

Fall Fact Forum

The Fall Fact Forum will be held on Monday and Tuesday, September 28 and 29 at the Crown Inns Motor Inn, Route 161 at I-71 in North Columbus.

On Monday, September 28 the Board will meet at 1:00 p.m., followed by a Board dinner at 6:30 and a Forum Rehearsal at 8:30 p.m.

For Tuesday, September 29, the program has been scheduled as follows:

8:30 to 10:00 a.m. — Registration and Continental Breakfast

9:45 — Welcome by Mrs. C. F. Goll, President
General Session — Mrs. R. L. Wiessinger, President-Elect

10:00 — Health Careers — Mrs. H. I. Humphrey
Mental Health — Mrs. L. A. Loria

10:45 — Safety and Self Defense — Mrs. V. H. Hinrichs
Parliamentary Procedure — Mrs. Edward Bauman and Mrs. R. O. Cooks

11:30 — AMA-ERF — Mrs. Karl Ulicny
Mrs. C. R. Crawley

12:30 p.m. — Weight Watchers Luncheon

1:45 — Auxiliary News — Mrs. H. W. Allison
Publicity — Mrs. R. E. Krone
Communications — Mrs. S. L. Meltzer
Health Education and Community Service — Mrs. H. Holden

2:30 — Break

2:45 — Legislation — Mrs. Paul Jones
Children and Youth — Mrs. H. W. Haverland

3:30 — Membership — Mrs. D. S. Wolff
Members-at-Large — Mrs. Kent Brown
Program — Mrs. R. L. Wiessinger

President's Message

Mrs. Carl F. Goll, state president, is especially interested in contacting all county auxiliaries this year. She writes: "I would like every county auxiliary to be visited by a state officer or a "Travel Team" from your state board this year. We can "team up" two or more of our state chairmen wherever or whenever they are needed. Requests for your state officers should be sent to our Central Office — or if you prefer — write directly to the chairmen. We would like to meet and visit with as many of our members as possible. Please take advantage of your state board. We would like to see your auxiliary at work."

Hats Off to the Counties

The real worth of medical auxiliaries is ably demonstrated at the grass roots level. Year after year county organizations participate in national projects such as AMA-ERF and Health Careers, hold interesting meetings covering a wide range of educational topics, plan social affairs to enhance good fellowship among physicians' families, and serve their communities in countless ways. County presidents give a capsule report of these worthwhile activities at the annual meeting in May. And I have been trying to find the space to give you a mini-capsule of these reports, starting last month in the August issue of *The Journal.*

Though the **Hancock County Auxiliary** was organized primarily as a social group, it does provide valuable service to the community. The group maintains membership and sponsorship of Twig 6 of the Blanchard Valley Hospital Auxiliary. Their continuing project is the rearrangement of all medical records of the hospital and the microfilming of same.

With a paid membership of 21 members **Hardin County** has an impressive list of activities as well as a close relationship with the Medical Society. The two groups meet jointly for dinner each month, then have their separate programs. The men underwrite the expenses of the Mistletoe Ball, biggest project of the Auxiliary, which netted $1500 for hospital equipment this last year.

Another 21-member group, **Huron County,** also manages a wide variety of projects. At Christmas time they packed and mailed 19 boxes for area soldiers fighting in Vietnam. They sold Christmas cards for the first time for AMA-ERF, collected drug samples, provided two student

nurses with interest-free loans, and assisted with several community activities.

Jefferson County Auxiliary reports a number of fund raising affairs to meet the demands for nurses' scholarship loans. Two dinners, a White Elephant Sale and a Monte Carlo Party have helped swell the treasury. Their regular luncheon meetings have been well attended and dinner parties seem to bring better fellowship and understanding among the doctors.

One of **Knox County**'s big projects is its Health Career Day Tea. Students from five county high schools and one new vocational school toured the hospital. Personnel from each department explained the type of work done, education needed, and job opportunities in each area. The Auxiliary provides a para-medical scholarship to a needy student choosing a health career.

With the slogan "In a New Light," **Lake County Auxiliary** was determined to make this a fruitful year. In cooperation with the Medical Society, Health Careers was chosen as the main project. Hospital tours were arranged for school superintendents, principals and counselors. The educators were then entertained at dinner and given an opportunity to ask questions about health careers. As a follow-up, auxilians were assigned to each high school to provide career information to students.

An average attendance of 13 out of 17 members at regular meetings is a percentage many auxiliaries would like to achieve. **Lawrence County** in its 20th anniversary year developed a "Memory Lane" theme and did just that. Auxilians entertained their doctor-husbands at two dinners, and the wives of local lawyers and dentists at a tea. Their AMA-ERF contribution was raised through the sale of Christmas cards.

To raise money for their scholarship fund, **Licking County** Auxilians donated food for a potluck dinner. Those attending paid three dollars each for the meal, all clear profit. Another project was assisting a community-sponsored rehabilitation program for young people who have come to the attention of Juvenile Court. Members provided funds and instructors so that the girls in foster homes could make Christmas decorations to sell to finance their own Christmas giving to their families.

Logan County's primary project is a Health Careers Loan Fund which is currently assisting one student. A secondary function is the promotion of fellowship among physicians and their families, a goal which is particularly valuable in a small community. Auxiliary membership (22) has almost always been one hundred percent.

A highlight of the year in **Lorain County** is the joint meeting of the Medical Society and the Auxiliary in December. Donated handicraft made by the doctors and their wives was sold at auction to raise scholarship funds. Everyone had a grand time and $2600.00 was raised! The Christmas card project was also quite successful, resulting in a substantial contribution to AMA-ERF.

Lucas County's most important community endeavor continues to be Mobile Meals of Toledo, Inc. This home-centered health care project has grown rapidly with current delivery of hot meals to 100 persons per day on 13 routes originating from four hospitals. About half of the 550 volunteers involved in the project are auxilians. In addition the auxiliary conducts several benefits to raise funds for Mobile Meals. Other auxiliary projects are AMA-ERF, Health Careers, International Health.

An important part of the program in **Mahoning County** this year was Drug Abuse. In October a joint meeting was held with school and community leaders to learn more about the drugs being misused by youth today. Then visits were made to all senior and junior high schools in an effort to educate the students. Finally in March a community workshop was held with films and

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speakers — over one thousand young people and parents attended.

Two joint dinner meetings of the **Marion County Auxiliary** and the Academy of Medicine were particularly successful this year. In November the dinner entertainment was an original skit, "Shades Near Blooming Grove," a satire on the medical profession with a bit of Marion history thrown in. Besides being written by a physician, the skit was a joint effort in casting. The International Dinner in February was a fund raising event for AMA-ERF. Each member of the auxiliary brought a covered dish representing a foreign country. Several members who are from foreign countries came in their native costumes.

In addition to having regular meetings and projects, **Medina County** offered its services to the community and school officials in the dissemination of information on drug abuse. The auxiliary purchased copies of the skit "Let's Get Basic" for the schools and will give financial support to whatever program the superintendent selects for the coming year.

Miami County continues to give priority to its nursing scholarships among other worthwhile projects. An annual dance is given to raise the necessary funds — this year was so successful that three $1000 scholarships will be given. The only stipulation is that the girls work in one of the three county hospitals for one year.

Montgomery County has a long list of accomplishments, some interesting programs, and a few "firsts" for the year. A Mother and Daughter Night Out drew a crowd of 241 and may be repeated annually, hopefully on the same night as the Medical Society's Father and Son Banquet! Health Careers Day reached 529 students and was backed up with a program available the year round — a carousel of slides showing medical personnel at work is shown to any school upon request.

"What To Do Until the Doctor Comes" was the delightful theme of the year for **Muskingum County**. The six meetings were planned around activities topics and hobbies designed to keep the doctor's wife happy in her role. The clever and original programs are well worth listing: (1) "Take Two Aspirin and Call Me in the Morning" — an amateur talent show; (2) "Acid, Amphetamines and Aunt Emma" — the drug abuse problem; (3) "6:55 and Holding" — family feeding problems with a taster's buffet of foods that could be held without losing flavor; (4) "First Aid for Husbands" — demonstration of a low fatty-acid diet; (5) "Mom's Night Out" — a discussion of financial matters; (6) "Sew What?" — a fashion show of garments created by members.

Ottawa County boasts 18 active members in a total of 21! The biggest project is the annual Careers Day tea for sophomore girls to interest them in nursing and other medical fields. They also have an annual picnic for all hospital personnel and staff. Mobile Meals is being instigated as a new project.

Pickaway County (13 members) identifies itself as a small group that "cooperates rather than initiates." The Auxiliary is Guild I of the General Guild of Berger Hospital and takes an active part in fund raising and other volunteer activities for the hospital.

Auxilians in **Richland County** have done much for their community in the past year. An auction of homemade gifts and foods raised funds for Christmas gifts for patients at the Columbus State Hospital. Golden Agers at Friendly House were entertained at a Valentine Party. A program on self-defense for women was well received by many guest organizations and was repeated for the public at an open evening meeting. An extra: Dorothy Bell, a former state president, had the privilege of installing her daughter as the county president!

The main project of **Sandusky County** was an expanded program on Health Careers. They sponsored a work-day for students in various hospital departments in addition to showing the movie "Horizons Unlimited" and conducting hospital tours. An especially interesting program was "Pioneer Doctors of Sandusky County" with a display of antique medical instruments.

Scioto County reports a busy and successful year with special emphasis on providing materials to the schools on three topics: health careers, drug abuse and self-defense. They also sponsored a booth at the county fair showing pictures of pills commonly mis-used.

An impressive accomplishment of **Stark County** was the fact that its members increased their AMA-ERF contributions by 100 percent over the previous year. The methods of collections included: Gold Rush Walk, YWCA bazaar, Memorial Fund, Christmas cards, sale of miscellaneous items from AMA-ERF, profit from sale of *Falls the Shadow*, style show and private donations.

Among the many useful projects of the **Summit County Auxiliary**, the "Rub Out Rubella" program was particularly successful. A total of 35,000 children in 145 schools and 10 clinics were vaccinated and $30,000.00 collected to help purchase the vaccine. In December money was raised for the auxiliary Chorus which presents programs to nursing homes and hospitals throughout the year.

Trumbull County reported a specific effort this year to bring back the attendance, the closeness and the oneness of the medical fraternity feeling that they once had when half their present

size. There were several combined dinner meetings with the Medical Society in addition to the regular daytime meetings of the auxiliary. Committee and project activity continued at a high level of success as before with a particularly outstanding program in Health Careers for high school students.

In addition to continuing its generous contribution to AMA-ERF as before, **Tuscarawas County** concentrated on meeting health needs of their own community. For the first time they contributed $1200 to the county branch of Kent State for scholarships in the Associate degree Nursing Program. In addition they have two students in other schools of nursing receiving substantial aid. A luncheon for Health Career Clubs, guidance counselors, and nurse loan-fund recipients was well attended.

Union County reports that its members volunteer their services to many community organizations and are especially active in hospital affairs. The big annual benefit for the Memorial Hospital raised over $4000.00 this year.

Principals In Student Health Project



Three Steubenville area physicians served as host physician coordinators for the 1970 Appalachian Student Health Project. The project, an endeavor conjointly undertaken by the Student American Medical Association and the Appalachian Regional Commission, was developed as an effort to create a program which would provide an educational experience for health professional students in rural and small city America. Participants in the Appalachian Student Health Project at the Ohio Valley Hospital are (left to right) Nancy H. Bright, M.D.; Paul Leber of Lewiston, Pa., a medical student at the University of Pittsburgh; Martin Newcomb, of Jackson, Miss., a medical student at the University of Mississippi; Doug Lane, of Weaverville, Calif., a medical student at Creighton University; F. J. Shaffer, M.D.; and Paul N. Mastros, M.D. The project's nine week "work period" from June 24 to August 19 included exposure to and participation in routine office practice, hospital routine, public health service, and individual projects. In setting up the program, the OSMA office provided liaison between SAMA and Sanford Press, M.D., of Steubenville, Seventh District Councilor and local organizer for the program.

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

EXCELLENT OPPORTUNITY: Large industrial private medical practice, Southwestern Ohio, wishes associate. Reply Box 547, c/o Ohio State Medical Journal.

IMMEDIATE OPENING: INTERNIST or General Practitioner to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practicing physicians (General Practitioners) in the community outside of our clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd., Two Rivers, Wisconsin 54241.

GENERAL PRACTITIONER OR INTERNIST—Available immediately. Busy practice for G.P. or Internist desiring family practice without Obstetrics. Group consists of 3 G.P.'s and Surgeon, in new building with lab and x-ray facilities. Local 50 bed J.C.A.H. approved hospital. Rural area with excellent school system. Ready access to Cleveland, Akron, Columbus. No investment. Early partnership. Housing available. Reply John A. Grafton, Business Mgr., Lodi Medical Building, 402 Highland Dr., Lodi, Ohio 44254 or phone (216) 948-1555.

PSYCHIATRISTS: Avoid pollution—enjoy fresh air, clean water, less people in a summer-winter vacationland near Interlochen Arts Academy. Small town peace and quiet. Big city culture and salaries. Progressive psychiatric hospital, J.C.A.H. approved, 3-year Psychiatric Residency Program. Salaries to $32,364 if you qualify, excellent fringes, housing available. Contact M. Duane Sommerness, M.D., Traverse City State Hospital, Traverse City, Michigan 49684.

UNIVERSITY STUDENT HEALTH PHYSICIANS: Two immediate openings, Northwest Ohio, 13,000 students, modern new facilities, 102 bed hospital and complete lab. & x-ray facilities; excellent salary, fringe benefits, vacation, and working conditions. Reply Box 590, c/o The Ohio State Medical Journal.

EMERGENCY ROOM PHYSICIAN — full or part time. High salary. Contract leading to partnership. Active, acute medical and traumatic service. No pediatrics. Ohio License required. Contact F. C. Witwer, M.D., Akron General Hospital, 400 Wabash Ave., Akron, Ohio 44307.

PSYCHIATRIC RESIDENCY — modern 120 bed hospital in Akron suburb, 40 mins. from Cleveland; comprehensive 3 yr. approved program. Area growing; high demand for psychiatrists. M. Menassa, MD., DME, Fallsview Mental Health Center, Cuyahoga Falls, Ohio 44222 (216) 929-8301.

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RETIRED RADIOLOGIST has building equipment for sale. Located at 328 E. State St., Columbus, Ohio across from Grant Hospital. Suitable for Radiologist, Internist or Orthopedist. Contact Dr. W. H. Miller, 328 E. State St., Columbus (614) 221-3743.

PSYCHIATRIC RESIDENCES: We offer nothing but excellent psychiatric training in a stimulating, well-organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, three year program: $11,359; $11,922; $12,925. Five year program: $12,945; $14,950; $17,393; $23,198; $24,409. NIMH-GP Stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

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INTERNIST—wanted to locate in a small progressive community. New modern Medical building adjacent to hospital available. Contact: Administrator, Southern Lorain County Hospital, Dickson St., Wellington, Ohio 44090.

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INTERNISTS AND PEDIATRICIANS: Openings with multi-specialty group of seven physicians seeking future partners in area serving N. Ridgeville and Elyria, Ohio (combined population of 75,000). Excellent opportunity to practice in a friendly fast growing community. High starting salary with liberal fringe benefits. Call Elyria (216) 365-7311 or write Edwin G. Haywood, Administrator, Center Ridge Clinic, Inc., 39000 Center Ridge Rd., North Ridgeville, 44035.

ASSISTANT MEDICAL DIRECTOR

Large diversified industrial firm (in Cincinnati area) is seeking a full time physician. This is a career opportunity in an internationally known company. A wide range of employee benefits. Reply Box 615 c/o The Ohio State Medical Journal.

An Equal Opportunity Employer

CENTRALLY AIR CONDITIONED FULL SERVICE OFFICE: Prime University Heights, Cleveland Heights, South Euclid intersection. Excellent for Internist, General Practitioner, Ophthalamologist, or other specialist. Opposite May's on the Heights. Doctors Center Bldg. 14077 Cedar Road, Cleveland, Ohio 44118. Phone 216-321-5060.

INTERNIST AND PEDIATRICIAN WANTED—Group of two general surgeons and one obstetrician-gynecologist looking for board qualified or certified internist and pediatrician. We are creating a partnership of young well trained physicians in a mutual complimentary practice. Incorporation is in process with excellent fringe benefits. We are located in north central Wisconsin serving a community of approximately 25,000 with a summer population of 200,000. We have excellent recreational and educational facilities including college. Starting salary is $25,000 wth partnership after one year. Anyone interested write to Dr. I. E. Schiek Jr. c/o The Schiek Clinic, Rhinelander, Wisconsin 54501 or call collect 715-362-6160.

STUDENT HEALTH CENTER at Virginia Polytechnic Institute has opening for Staff Physician. Good fringe benefits. Salary $20 to $22,000. Ideal area for family living. For further information write or phone, Emory R. Irvin, M.D., Director, Student Health Center, Virginia Polytechnic Institute, Blacksburg, Virginia 24061. Phone 703-552-6444.

EMERGENCY ROOM PHYSICIAN WANTED to complete group. 40 hour week. No private practice allowed. $25,000 annual guaranteed plus percentage. Present group operating successfully. Accredited hospitals with opportunity to assist major surgery for additional remuneration. A southern Ohio city. Ohio license required. Call collect either J. T. Gohmann, M.D., or M. J. Daus, M.D. 614-354-5315.

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

PSYCHIATRIST —To direct M.H. Clinic in city of 35,000 in N.W. Ohio. Staff includes Ph.D. and M.S.W. Salary range $25,000 + liberal fringes. Contact W. B. Elderbrock, M.D., 111½ W. Pearl, Findlay, Ohio 45840.

NORTHFIELD, OHIO — Physicians who are state licensed or holding ECFMG, required for institutional practice in a hospital located near Cleveland, Ohio. Living quarters and other benefits available. Write or call Eliere J. Tolan, M.D., Superintendent, Hawthornden State Hospital, Box 305, Northfield, Ohio, 44067 or call A.C. 216-467-7131.

INTERNIST board certified or eligible sought by 30 man multispecialty group in southeastern Ohio. Outstanding professional opportunity in modern medical facilities, located in pleasant, safe community. High salary first year, then partnership. Call or write Oscar W. Clarke, M.D., AC 614 446-1332, or Charles E. Holzer, Jr., M.D., AC 614 446-2244, The Holzer Medical Center Clinic, Gallipolis, Ohio, 45631.

ELECTRIC STAIRWAY FOR SALE: Slightly used, single seat "Inclinator," suitable for invalids. Contact R. L. Mansell M.D., 212 S. Broadway, Medina, Ohio 44256. Tel. 723-7591.

OHIO, FAIRFIELD: Space available in modern Medical Building. 15 miles from Cincinnati, General Practitioner and Specialist needed. Reply Box 616, c/o The Ohio State Medical Journal.

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STAFF PHYSICIAN — Full-time staff physician needed for Intermediate Service 732 bed general medical and surgical hospital. Ohio State University Medical College affiliated. Faculty members conduct conferences, clinics, and participate in a diversified residency training program. Medical license in any state acceptable; salary range $19,643 to $25,937 per annum depending upon qualifications. Moving expenses paid. Maximum leave and insurance benefits; noncitizens will be considered; nondiscrimination in employment. Write: Center Director, Veterans Administration Center, 4100 West Third Street, Dayton, Ohio 45428.

WANTED — General and specialty practices. We offer a confidential and ethical service to sellers. Contact Professional Practice Sales, P.O. Box 24221, Cleveland, Ohio 44124 or call 216-449-1059.

RETIRING FROM THRIVING EENT practice in Central Ohio; wish to sell my almost new, nine-room, one-story office building with furniture, and equipment; good parking. Phone: Coshocton (614) 622-3505 or 622-2605 (residence).

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Clean air, fishing and beaches. Emergency room physicians needed full time for expanding Florida Hospital. Must have Florida license and qualify for Active Staff privileges. Fee for service with guarantee of $219.00 per 24 hour day. No overhead. Hospital does billing of fees at no expense to you. Write E. Gilbert Slatton, Administrator, Wuesthoff Memorial Hospital, Rockledge, Florida 32955.

Seminars at Ohio Colleges Will Spur Interest in the Medical Sciences

The Ohio State Medical Association, in cooperation with the American Medical Association, is cosponsoring a program of seminars and a lecture in the medical sciences to be given at 11 universities in Ohio during the 1970-71 academic year.

The AMA Council on Foods and Nutrition initiated this program in the fall of 1964. It is being carried out on a regional basis with a total of 84 lectures being scheduled this year in the following 14 states: Connecticut, Delaware, Illinois, Indiana, Maine, Massachusetts, Michigan, Missouri, New Hampshire, New York, Ohio, Pennsylvania, Rhode Island, and Vermont.

The purpose of the lecture is to inform students and faculty of recent developments and to stimulate interest in the medical sciences. The lecturers will be on campus for the entire day to give undergraduate or graduate seminars and also to meet informally with students and faculty interested in discussing careers in medicine and related fields.

Dr. Denis Abelson, director of the Clinical Research Center and associate professor of medicine at the University of Pennsylvania in Philadelphia, will speak on "Research and Discovery in Medical Science" at the following schools:

Central State University In Wilberforce
Tuesday, October 20

Miami University In Oxford
Wednesday, October 21

Dr. Lewis Barness, chief of service, Department of Pediatrics at the University of Pennsylvania School of Medicine in Philadelphia, will speak on "Nutrition and Brain Development" at the following school:

College of Wooster in Wooster
Thursday, November 5

Dr. Donald Berkowitz, associate professor of medicine at Temple University Medical School in Philadelphia, will speak on "Malnutrition as the Result of Plenty" at the following school:

Youngstown State University in Youngstown
Friday, October 23

Dr. George Owen, Associate Professor of the Department of Pediatrics of the College of Medicine at Ohio State University in Columbus, will speak on "Food, Nutrition and Health: Preschool Children" at the following schools:

Marietta College in Marietta
Tuesday, September 29

Ohio University in Athens
Thursday, November 12

Wittenberg University in Springfield
Wednesday, January 13

Ohio Northern University in Ada
Wednesday, February 10

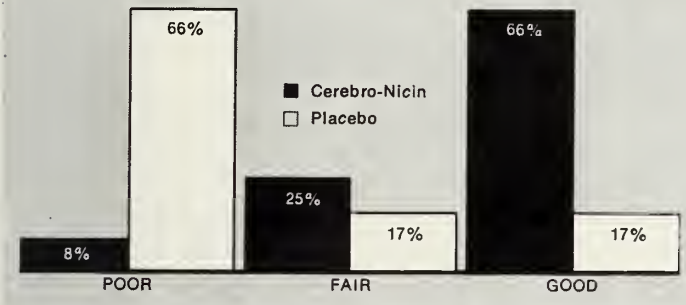
Muskingum College in New Concord
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For the treatment of the aging patient

Cerebro-Nicin®

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A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
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DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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NEW CLINICAL STUDY

in the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society



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(thyroid-androgen) tablets



Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Ketosteroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

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Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
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OCTOBER 1970
Vol. 66 • No. 10

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

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LIBRARY OF MEDICINE

27 OCT 1970

Named OSU Vice-President for Medical Affairs



RICHARD L. MEILING, M.D., Dean of the OSU College of Medicine, has been named to the University's newly created office of Vice-President for Medical Affairs. Turn to Page 1059 for more information.

OTHER FEATURES

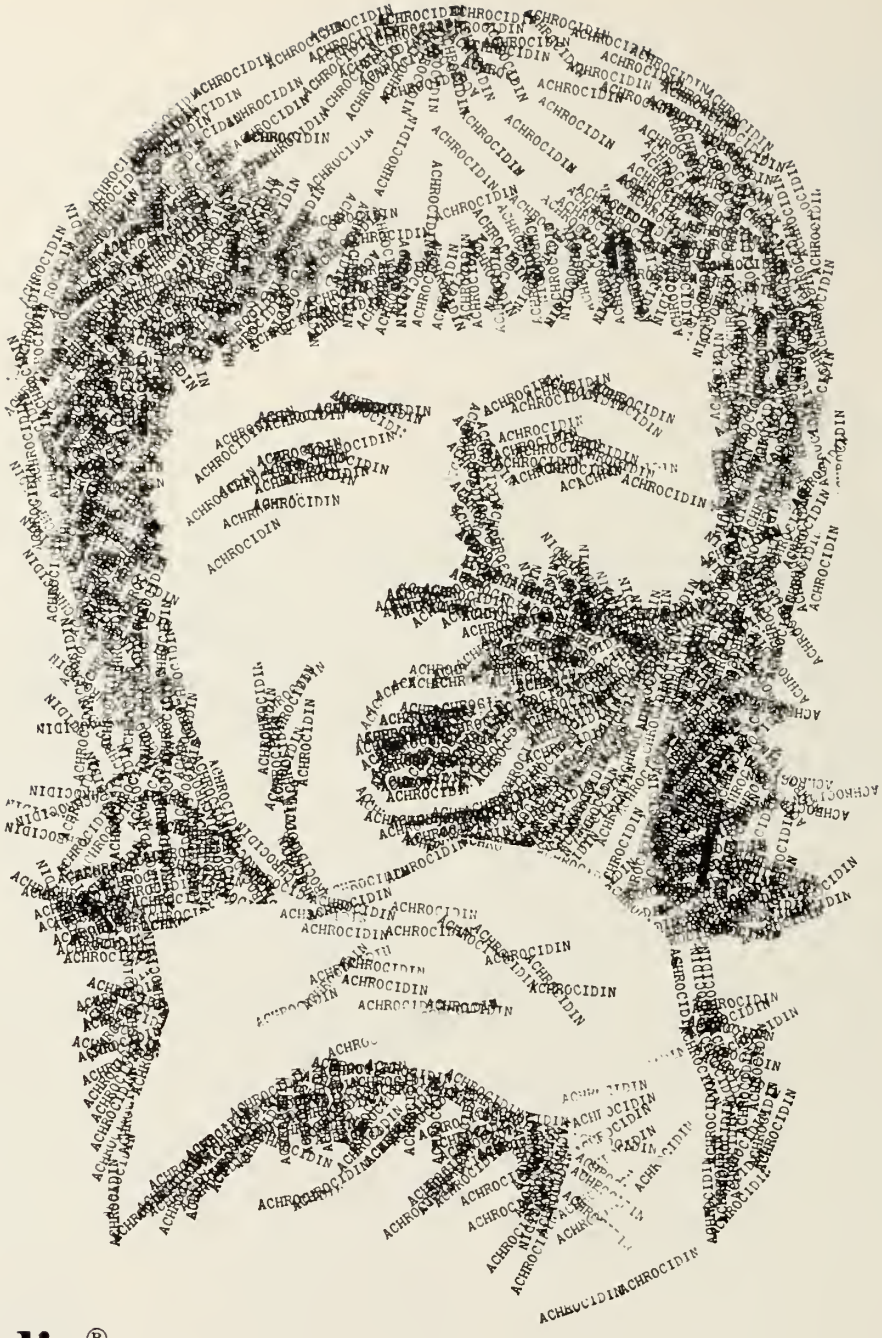
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Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

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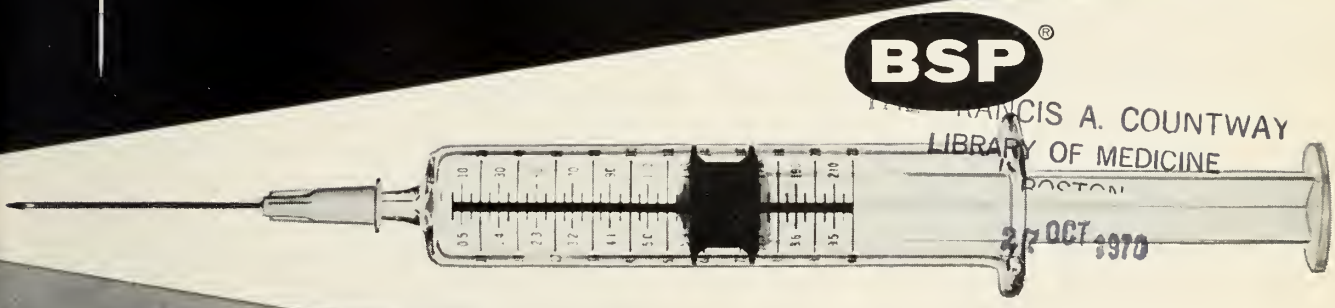
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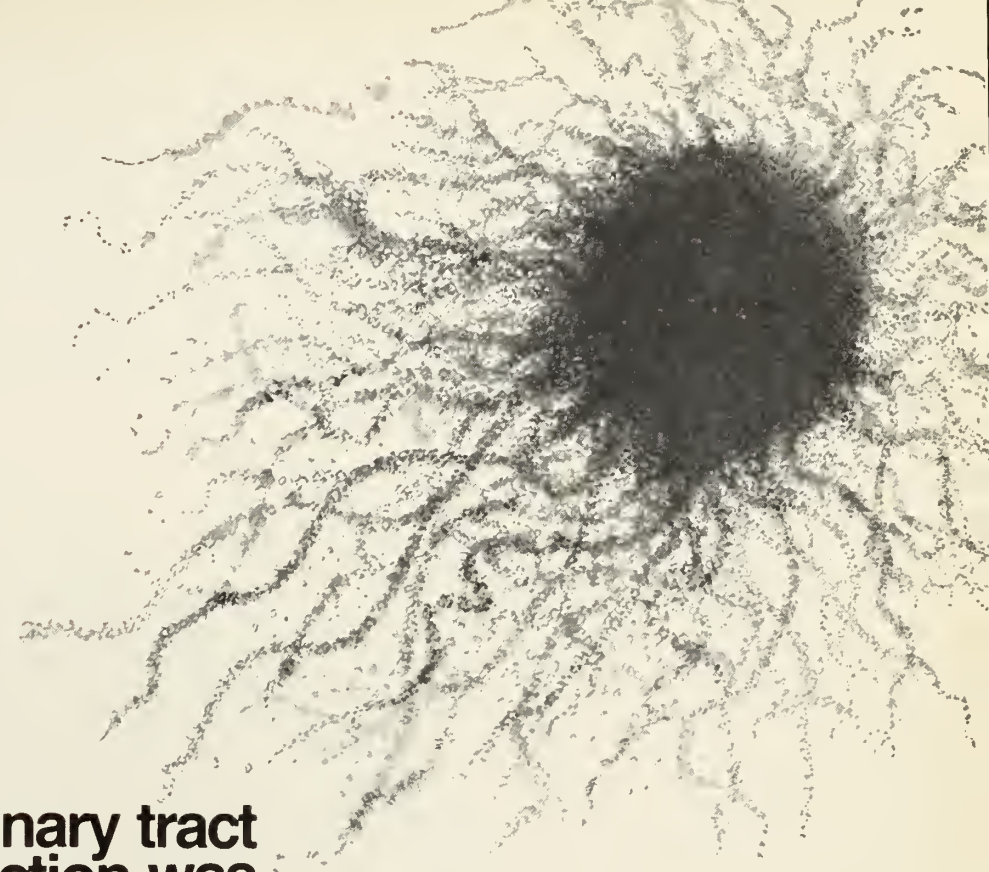
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Intestinal monilial overgrowth has appeared this week

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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

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A Perspective on Health in an Appraisal of the Environment

By Emmett W. Arnold, M.D.
Director, Ohio Department of Health

WE ARE IN AN IMPATIENT ERA, an era when the people are conditioned to demanding and even expecting instant health. No longer does nature get a chance to heal the body over time; at the first symptoms the self-diagnoser starts the pills.

And we are witnessing a similar impatience with the suddenly perceived ills of our physical environment. The instant cure is demanded, and the cure proposed is usually as superficially determined as is the cure for the cold, allergy, ache, or pain.

There is another similarity. The cure may well mask a symptom of some more serious disease or it may divert attention from the diagnosis which would have determined the underlying cause. It may even cause other bodily or environmental harm.

Yet our environment, irrespective of its physical characteristics, is of little value unless used and enjoyed by people. This in turns means that unless people are healthy — mentally, physically, and spiritually — they won't enjoy any environment. This recognition places not only a responsibility but also a challenge on those in society who have the task for caring for human health.

Increasingly there is an awareness of the total environment and the total health of people. Fantastic strides have been made in guidelines and methodology for curing and even preventing health handicaps. We in Ohio can take pride in the progress to date in this state. But we can't rest on those laurels for our efforts still fall far short of controlling either environment or health.

Major Areas of Concern

These are our challenges—either as practitioners or as leaders who can define problems or interrelationships and interstresses which can be appraised and answered by others.

In this summary of major areas of health concern I hope to make two points—how far we have progressed and what remains to be done if we are to better control our health and environment. And then I would hope that as we consider these areas which are normally considered as specialties there would be a questioning of the validity for such categories, a questioning of the causes and assumed correlations so that the picture of health and environment merge into a single picture.

Let me offer some illustrations. In an era when pollution has suddenly become the source of concern and worry to many and the source of political and research plums for others, the public should be relying on the public health authorities for counsel. However, there really is no unanimity among the health authorities and the conflicting opinions offered with gusto command no public respect for the field. Without discussing possible motivations or constraints which individuals might justify, let me point out that our efforts to fully identify cause and effect under this cloud of hysteria leave much to be desired.

For example, health in Ohio ranks among the top in the nation. And Ohio has a variety of influences on the environment—both natural and manmade—which also ranks among the top states in the country. Ohio has ongoing programs for abatement of air and water pollution which rank second to none in the nation. And yet Ohio reads of criticism by persons in distant cities who, ignorant of the facts, makes assertions which suggest Ohio is not doing a job in protecting the environment. The inference is that health in Ohio is jeopardized. No figures; just an accusation. But by the same token, we lack data to show that the health in the so called polluted areas is not comparable to the cleaner areas; we also lack the data to show whether eating habits living conditions, mental attitudes or working schedules are causal factors in variation around the state. We have opinions; we lack data on the total environmental effects on man.

Or consider this example. The controlled ingestion of fluoride has been demonstrated to min-

(Continued on Page 987)

This article is the transcript of an address given by Dr. Arnold on June 2, 1970 at a meeting of the Ohio Public Health Association in Cincinnati.


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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
5. Four tablet strengths to allow flexibility of dosage (usual starting dose: for the problem drinker, 10 mg. t.i.d.; for the frank alcoholic, 25 mg. b.i.d.).
6. Injectable form available for acute episodes.



program for early recognition and successful treatment:

Alcoholism in Ohio*

State Rank	
total no. alcohalics	5th
na. per capita	13th
per capito consumptian†	30th

Ohio Physicians' Report
(compared with U.S. average)

	%Ohio	%U.S.
see 5 or mare problem drinkers in 2-month period	33.8	37.1
half or mare seen are wamen	38.0	37.4
treat, rather thon refer	73.7	72.6
more community services needed	64.0	63.0

*based on preliminary data supplied by Center of Alcahal Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory**, a nationwide survey of treatment centers.

Interested? Complete and mail this coupon to:
Dept. SERENTIL/Sandoz Pharmaceuticals
Route 10/Hanover, N. J. 07936

SANDOZ

Dr._____
(PLEASE PRINT)

Street_____

City_____ State_____ Zip_____



See next page for prescribing information.

SERENTIL®
(mesoridazine)
new weapon in the fight against alcoholism

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few (rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible. There is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arrest has been noted.

Extrapyramidal Symptoms: Akathisia, agitation motor restlessness, dystonic reactions, trismus torticollis, opisthotonos, oculogyric crises, tremor musculor rigidity, akinesia—some of which on rare occasions have persisted for several months or years especially in patients of advanced age with brain damage.

Endocrine Disturbances: Menstrual irregularities altered libido, gynecomastia, weight gain. False positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects suggestive of a paradoxical reaction have been reported. These include excitement, bizarre dreams, aggravation of psychoses and toxic confusional states. More recently, a peculiar skin-eye syndrome has been recognized as a side effect following long term treatment with phenothiazines. This reaction is marked by progressive pigmentation of areas of the skin or conjunctiva and/or accompanied by discoloration of the exposed sclera and cornea. Opacities of the anterior lens and cornea described as irregular or stellate in shape have also been reported.

DOSAGE AND ADMINISTRATION: Oral: The dosage of Serentil (mesoridazine), as in most medications, should be adjusted to the needs of the individual. The lowest effective dosage should always be used. When maximum response is achieved, dosage may be reduced gradually to a maintenance level.

Alcoholism: For most patients the usual starting dose is 25 mg. b.i.d. The usual optimum total daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless of severity, a starting dose of 50 mg. t.i.d. is recommended. The usual optimum total daily dose range is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: For most patients a starting dose of 25 mg. t.i.d. is recommended. The usual optimum total daily dose range is 75-300 mg. per day.

Psychoneurotic Manifestations: For most patients the usual starting dose is 10 mg. t.i.d. The usual optimum total daily dose range is 30-150 mg. per day.

Injectable Form: In those situations in which an intramuscular form of medication is indicated Serentil (mesoridazine) Injectable is available. For most patients a starting dose of 25 mg. is recommended. The dose may be repeated in 30 to 60 minutes, if necessary. The usual optimum total daily dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg. and 100 mg. mesoridazine (as the besylate). Bottles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the besylate)]. Inactive ingredients—Disodium Edetate U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg.; Carbon Dioxide Gas (Bone Dry), q.s.; Water for Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 100.

SER70-101

Sandoz Pharmaceuticals, Hanover, N.J.

imize dental caries. This fact is supported by all nationally recognized health authorities and yet it is not universally accepted by the public. Less well known are the studies which indicate traces of vanadium in water supplies are correlated with 50 percent reduction in coronary deaths as compared to states which do not have this trace element. Of even greater importance is the reported lack of a statistically significant difference between urban and rural residents in coronary rates if vanadium is absent. This is but one of the factors not fully assessed in the proposed carbon monoxide standards which uses the coronary rate as a control.

Similarly, traces of selenium appear to reduce arteriosclerosis, and endemic anemia flourishes with a deficiency of iron.

I offer these illustrations merely to emphasize the necessity to consider all factors of the environment—air, water, food, and the social as well as mental stimuli which can affect a study proposing causal relations.

With our present kick on purity—or rather a kick against pollution—the assumption is easily justified that impurities are bad. We made that mistake a number of years ago when the demand was for a pure flour. You recall we finally got a pure flour but it had one drawback—it was useless. Now we add the impurities which were then removed but in higher concentrations and call it fortified or enriched flour.

Our horizons are broadening. I simply urge that tendency become a trait. So with that let's consider some of the general areas.

Births

The infant and fetal mortality rate in Ohio is less than half what it was 30 years ago. The infant death rate has dropped from 41.2 per 1000 live births in 1940 to 20.3. The fetal death rate has dropped from 27.5 in 1940 to 13.3.

An even greater improvement has been shown in maternal mortality. From 31.9 deaths in 1940 per 10,000 live births, the rate is now only 2.6. The remaining challenge lies principally in providing prenatal care to low income families. Only 12 of our 88 counties provide clinic service of any kind.

Preventing mental retardation got a big assist by legislation in 1966 making mandatory a serum phenylalanine determination 48 hours after the first protein feeding. The prevention of unnecessary hardship and heartbreak for parents via this screening most assuredly improves the quality of their environment.

Childhood

Availability of accessible child health services for children to age 21 will reduce later dependency as well as promote health. This remains as a challenge but the progress in Ohio in reducing percentage of children with hearing, vision and speech deficiencies attests to the excellent staff work in our POD (Pediatric Otolaryngolical Diagnostic) clinics and speech therapy centers. There are now 32 POD clinics covering 70 counties, and 30 speech and hearing centers in 30 different counties.

At least 2 percent of Ohio preschool children suffer hearing loss, 5 percent vision impairment and 3 percent speech disorder. As children age, the percentage of deficiencies increases until by school age 2.5 percent to 3 percent suffer some loss of hearing and 11 percent have vision impairment.

Some of the childhood problems relate to diet deficiencies. There is also indication the addiction to hard rock music is having its toll on damage to the ear. Again, these are environmental relationships entirely apart from normally considered health problems. The cure will undoubtedly require education of parents and training of children for tests made by the Department have shown that availability of proper food fare is not of itself sufficient. For example, 261 fourth grade students in seven schools were checked over a 24 hour period. Seventy-five (29 percent) did not eat the recommended meals and 12 (5 percent) did not eat any food. The selectivity was even more pronounced: 80 percent did not eat the vegetables and fruit; less than 10 percent ate the food source of Vitamin A.

Dental Health

If the national studies hold in Ohio, some 8.7 million Ohioans need dental care. Dental health results from dental health education and although two-thirds of the state's school children now receive such an education, the challenge remains to make it available to the remaining children. But dental health awareness and implementation must not stop with children in schools; it must be continuing throughout the adult life.

Alcoholism

How serious the problem of alcoholism is can be determined from a Battelle report:

⅓ of arrests by municipalities are alcohol related.

(Continued on Page 990)

Menrium® treats the menopausal symptoms that bother him most.



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through *her* menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

(**Health Report**—*Continued*)

$7 million annually cost to arrest, prosecute and incarcerate 50,000 to 75,000 individual problem drinkers.

½ of all fatal accidents in U.S. are caused by drinking drivers.

300,000 Ohioans are alcoholics.

1,200,000 Ohioans affected by alcoholic habit.

3,111 counselling sessions in 1969 with alcoholics in 14 alcoholism centers in Ohio.

The inability of the criminal justice system as presently constituted to deal with the underlying medical, social and personal problems of an alcoholic is clear. He is a sick man and here again lies a challenge of major proportions.

Communicable Disease

The incidence of communicable disease in Ohio is much lower than in other states, according to the most recent figures published by the National Communicable Disease Center. We are below national averages in cases of amebiasis, infectious hepatitis, malaria, pertussia, rubella, shigellosis, streptococcal, tetanus tularemia, typhoid fever, typhus fever, syphilis, gonorrhea, rabies, chickenpox, conjunctivitis, mononucleosis and new active tuberculosis.

I am proud of the progress that has been made in controlling tuberculosis during the past seven years. Newly reported active cases of tuberculosis declined from 2,439 in 1963 to 1,258 in 1968. Newly reported cases for this period dropped off only 21 percent nationally, compared to nearly 50 percent in Ohio. Deaths due to tuberculosis declined from 435 in 1963 to 248 in 1968. The number of patients hospitalized in tuberculosis hospitals declined from 1,518 in 1963 to 719 in 1969.

Now that rubella vaccine is available in sufficient quantities, immunization against rubella will be required for all school enterers in September. Mass rubella immunization programs are being conducted throughout the state at this time. This immunization program will eliminate rubella as a disease in Ohio and will put an end to much of the heartbreak caused by abnormal births.

Forty-six county-wide rubella immunization programs have been conducted with approximately 725,000 immunizations being administered to children ages 1 year through 10.

Twenty-six additional county-wide programs are already scheduled for this summer and fall.

Vaccine in single dose vials is available for routine clinic use in the local health departments.

Approximately 35,000 single doses have been distributed.

Total rubella immunizations 760,000. (State, federal, and locally purchased vaccine.)

Major areas where programs have been conducted:

Akron—Summit County
Youngstown—Mahoning County
Canton—Stark County
Elyria—Lorain County
Toledo—Lucas County
Cleveland—Cuyahoga County
Dayton—Montgomery County
Columbus—Franklin County
and 19 of the 29 Appalachian counties

It is expected that countywide rubella immunization programs will be completed by June 1971.

While we have done well in controlling communicable diseases in Ohio, we have had more than our share of aseptic meningitis, meningococcal infections, mumps, trichinosis, diseases affecting the central nervous system, and respiratory infections. However, of the 7,702 cases in these categories, only 764 were serious in nature.

Death

The leading causes of death in Ohio parallel the other states—heart, cancer, and strokes accounted for 68 percent of the deaths in Ohio in 1968.

Accidents caused about 5 percent of the deaths in that year; influenza and pneumonia 3.3 percent; diabetes 2.4 percent, and early infancy deaths 2.3 percent.

Pollution Control

Supplementing the efforts to protect the individual from disease is the effort to protect his environment—air, land, and water.

The Ohio Board has developed a reputation of moving determinedly after defining the specific objective and appraising the reasonableness of a time schedule to achieve that objective.

That reputation is not considered lightly. Nor was it earned easily. For nearly 20 years the Water Pollution Control Board has persistently developed a continued progress in abating and preventing water pollution. Selling a program over these years was often a lonely job because the strong public support present today was often lacking. It meant that facts had to be assembled, properly interpreted and presented.

Paradoxically, the increased public concern over pollution has created a dilemma for the regulatory administrator for now the public expects immediate solutions. The impatient do not

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories



With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

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WALKER, CORP & CO., INC.
Syracuse, New York 13201

realize that facts must still control; that when requirements are established they must be achievable and fair. Otherwise, the Board could not carry an enforcement action into court with an assurance of successful prosecution. The cities and industries know this is the practice of the Board and thus respect requests for action.

Ohio has assumed the role of leader but at the same time has evidenced its intention to be tough when the pollution does not move. Since 1963 when I became chairman of the Board there have been more than 600 enforcement hearings compared to only 156 during the preceding 10 year period. With the increase in data and knowledge of possible corrective techniques this program has accelerated.

The Board has also prohibited new construction in communities when the municipality drags its heels in following time schedules adopted by the Board. This "building freeze" has been an effective tool and is not employed unless absolutely necessary.

A measure of the effectiveness of the program is seen in the fact that 80 percent of Ohio's population has secondary treatment. During 1969 Ohio Department of Health engineers approved detailed plans for 389 sewerage projects costing over $117 million. With the passage of legislation in 1968 establishing the Ohio Water Development Authority (OWDA) there was a mechanism to assist the communities which are financially hard pressed.

The story on air pollution does not have the same lengthy history. When the Air Pollution Control Law was enacted in 1967, Ohio already had a voluminous file of technical information concerning the air pollution problem areas. The Department's air pollution control unit has been operating a statewide network since 1963. The Ohio Air Pollution Control Board has held public hearings for ambient air quality standards in Cincinnati, Cleveland and Ironton. Strict demands are being adopted and the Board has announced that the standards will be enforced.

The progress in abating air and water pollution is real and continuing. However, as population increases there will be new problems which will require innovative approaches. The gross visible pollution which now exercises the people will not exist but the increase in dissolved solids, for example, in surface waters can be a very serious quality impairment. Thus it is essential that our programs be based on facts, not emotions, and be sustaining rather than directed toward short term interest.

Collection and handling of sewage from the fringe areas of communities remains a major challenge and cost. So does the control of quality in

ponds and lakes affected by agricultural drainage. And to top this, there is the solid waste problem. This is of greater concern to many than either air or water pollution. It is easy to see their concern for land is rapidly becoming scarce in metropolitan areas so old style disposal methods are obsolete.

Your background permits you to see how the health of the individual is interrelated to his environment—at home, in school, at work, at play. Our problem lies in getting a public awareness of this. No better challenge summarizes the purpose and role of the Public Health Association and I suggest the Ohio Chapter take the lead in an Association program for such an educational effort.

Ohio VA Hospitals to Get Research Facilities

With research a vital part of the Veterans Administration's vast medical program, Administrator Donald E. Johnson has announced that research additions costing $11 million will be constructed at eight of its hospitals.

The VA has some 6,000 research projects currently under way at many of its 166 hospitals most of which are affiliated with university and college medical schools.

The new buildings will be constructed at VA hospitals in Cleveland, Cincinnati, Ann Arbor, Mich., Philadelphia, Oklahoma City, Okla., Wilmington, Del., Albuquerque, and Jackson, Miss.

Columbus State Hospital Will Host Physician Group

The next meeting of the Association of Physicians of the State of Ohio is to be held Friday, October 16, at the Columbus State Hospital, 1960 W. Broad St., Columbus, starting at 9:00 a.m. and finishing at 4:00 p.m.

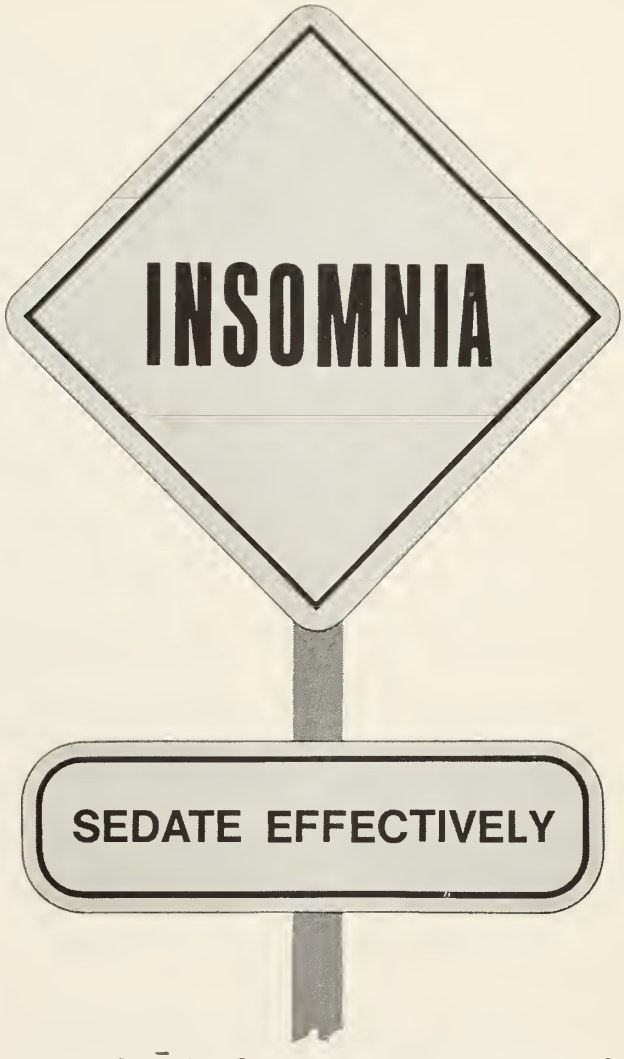
Herbert C. Modlin, M.D., Menninger Foundation, will speak on the "Anti-Social or Criminal Personality."

George Lohrman, M.D., Ohio State University, will discuss "Problems of Providing Emergency Care in an Outpatient Setting."

Theodore Sills, M.D., Columbus State Hospital, will present "An Interesting Patient—Unusual Medical-Legal Angles."

Also, there will be a short business meeting with election of Officers for the following year.

Future meetings are tentatively scheduled January 9, 1971 at Lebanon Correctional Institute, and April 16, 1971 at the Fairfield School for Boys.



With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

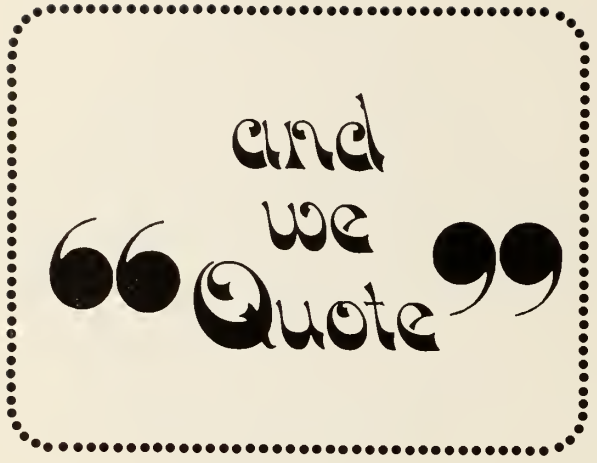
QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

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The Wisdom of Yesterday— a Gauge of Today's Progress

"History teaches us that even now we should only occasionally talk about 'curing' people. We should acknowledge how much our predecessors could achieve by using to the utmost their modest aids and *their personality,* in contrast with the modern mechanised systematized routine. Naturally one should not decry progress; it has been enormous, especially in the field of therapy, the only one the public recognizes—only to demand more!

"Progress has particularly affected certain diseases we could not heal until recently; now it is positively improper to die of them. But many of the small and disabling diseases remain and it is still true that a cold lasts seven days without and one week with therapy."—Professor Wilhelm Loeffler, Zurich, in the *World Medical Journal*

Fountain of New Ideas for the Present

"July is a high point for our medical community because of most of the members coming out of their residency about this time. It is hoped that we can encourage a good number of these men into Academy activity. They are our hope in the future and fountain of new ideas for the present." —Robert S. Heidt, M.D., in the *Cincinnati Journal of Medicine*

"Medicine, Like Music, Is a Universal Language"

"I am delighted to open officially this Symposium on Medicine and Diplomacy in the Tropics, for I have always felt that medicine, like music, is a universal language. The healing arts permit and promote international understanding —and international understanding is the way to international peace and security.

"Medicine as a universal language knows no boundaries of race, religion, or sex but operates in the interest of all humanity. Dr. Kevin M. Cahill, who knows so well our needs in Africa, has called attention to medicine as an untapped resource in diplomacy. We in the tropics, the developing nations, have great need for medical assistance and we ask your help. Those with respect and love for the human family will not want the benefits of health restricted to a particular geographical area, and efforts such as yours today should assure a better future for all mankind." — The Honorable Angie Brooks, President, The General Assembly of the United Nations, in the *Bulletin of the New York Academy of Medicine*

Putting a Professional Tag on Professional Training

"Let's drop the word 'resident' as an irrelevant anachronism. Let's present Post MD education as an elegant graduate experience—similar to other graduate professional disciplines—with vigor, pertinence, scholarship, and a bill for tuition! Let's encourage our Post MD (licensed-to-practice) colleagues to be compensated like other professionals at that level . . ." — Ernest W. Johnson, in the *College of Medicine Journal,* Ohio State University.

Moonlighting and Reflections of Community Needs

"Isn't it time for us to shed this hypocrisy—unintentional, perhaps, but nevertheless hypocrisy about the evils of moonlighting? How can one encourage house officers, on the one hand, to volunteer to work in 'ghetto' clinics, to perform camp physical examinations or to help man community projects and, on the other hand, forbid them to staff local emergency rooms or provide a modicum of medical supervision to a nursing-home patient? As I see it, the only difference is that money is involved—and aren't we past the stage of thinking that everything concerned with either sex or money is inherently 'verboten'?

"Possibly, it is already too late to address this issue aggressively. Conceivably the initiative is no longer with training program directors. And perhaps it ought not be. Nonetheless, couldn't an on-



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top-of-the-table effort be made to analyze the problem and test out alternative potential solutions. Conceivably, we medical educationists might reverse our field when confronted by data — and not simply by convictions." — William O. Robertson, M.D., in *The New England Journal of Medicine*

Time Erosion Syndrome and the Vanishing Volunteer

"One fallout increasingly evident at the front lines of medical care (but not yet apparent to social planners at the seat of government) is the *time erosion syndrome.*

"Caught between the exploding cost of doing business and third-party fee-fixing, the private physician has only the alternative of greater volume (and efficiency) if he is to run enough faster to stay where he was. If quality is to be maintained, then increased volume must be purchased with time and ruthless efficiency . . . .

"It follows that time once freely spent in volunteer teaching, hospital and organizational committee work is running out . . . ." — Clyde Stanfield, M.D., in the *Rocky Mountain Medical Journal*

The Best Hope of a Better World

There seems to be conclusive evidence that men today understand women and children better than their own grandfathers did. They are more sensitive, more tender, and more satisfied with the relationship within marriage and the family.

"This needs stating, because much of the literature today dwells too much on the negative aspects of married life. Much is wrong with the modern family, but much is also right with it. It is still an important primary group in which love and affection are shared among its members. It is still the most important agency in shaping personality patterns of children. It is still the best hope of a better world." — The Rev. Joseph L. Lennon, O.P., Vice-President for Community Affairs, Providence (R.I.) College, in *Rhode Island Medical Journal*

Establishing Communications with News Media Personnel

"I would encourage all county medical societies in the state to consider holding dinner meetings with the press representatives in their communities to promote better understanding between our profession and theirs. I would suggest that newspaper publishers, editors and working press should be invited to such dinners along with general managers, news directors and newsmen from television and radio stations . . . .

"We of the medical profession need to become better acquainted with the representatives of the news media so that they will find it easy to contact us for information on matters in our field before 'jumping off the deep end' on questions concerning medical matters and the public health." — Joseph L. Fisher, M.D., in *Missouri Medicine*

More Physicians to Take Care of One Patient

"In the last 50 years medicine's scientific and research orientation has resulted in a fantastic knowledge explosion. The outcome has been the fragmentation of health care delivery which became disease, system and organ oriented instead of patient oriented. A massive shift to specialization with its special challenge and status has been a natural consequence. All of the specialists need hospital facilities and some need complex equipment. Many must practice in high density population areas to draw enough patients with problems peculiar to their specialties. These things in turn lead to a greater institutionalization of care in urban centers. At the same time it leads to further physician shortage because it takes more physicians to take care of that one patient . . ." — Jack L. Gibbs, M.D., in the *Illinois Medical Journal*

Making Others Aware of Our Lack of Perfection

"Here again one can honestly say that the majority mean well, however, there is a minority who are out of line but if we spend all of our effort on the minority we will still not erase the complete problem of malpractice and probably in the long run will not even seriously alter the course.

"I say this, gentlemen, because of the fact that none of us practice perfect medicine and what is more none of us know what constitutes perfect medicine. I don't say this to be derogatory or to deride the progress of the profession but only to point out the fact that we still have a lot to learn and a long way to go. It does not seem just, however, that we should be penalized for our lack of knowledge especially when we realize the tremendous growth the medical profession has seen in the past 30 years.

"It would seem to me, however, that we do need to make others aware of our lack of perfection especially the patient who can and does end up many times with a result less than what he expected." — Dan Gowans, M.D., in the *Utah Medical Bulletin*

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Editorial

Postgraduate Education: Training or Travesty?

The question of post-M.D. education, which includes interns, residents, trainees, fellows and scholars, is again brought into focus by the dictatorial demand of the Board of Trustees of the National Intern and Resident Matching Program that hospitals sign an amended contract prior to July 15 on an "all or none basis."

It immediately becomes obvious that the NIRMP visualizes a loss of "business" (each hospital or institution pays $600 to enter into this program and each medical student pays $4) in this transitional time in the post-M.D. education in which, beginning with the Millis Report, the medical profession and many of the medical educators are attempting to reduce the time span in both medical education and post-M.D. education.

Here is an organization, namely the NIRMP, that says the goal is not to reduce the time, it is merely, to quote from the NIRMP letter of June 18, 1970, a differentiation in the "semantics" involving the title a physician has when he leaves medical school and enters post-M.D. education.

For some reason, the American Medical Association's Council on Medical Education, the NIRMP, and others are using every means at their disposal to prevent a restructuring of medical education for the good of both the public and the students.

In no other educational endeavor are the graduate professional students required to sign a contract that they will attend or pursue an educational program. The only exception is the various disciplines of medicine.

If, indeed, a contract is necessary, then the physician should be paid by the contracting institution a salary commensurate with his eight years, or perhaps less, of higher educational achievement for the services he has rendered. By the same token, if he is to pursue an educational program in a duly accredited educational institution, then he should not be bound by contract but he should be a free agent and his educational program should be flexible and adaptable to his capabilities, his motivation, and his goal.

Unless medicine accepts this as its challenge in post-M.D. education, the "unionization" of physicians, frustrated by lack of educational opportunities and confined by service demands of an institution, such as the hospital, are bound to wreck graduate professional medical education at all levels.

Highway Safety Literature Available

The Ohio Department of Highway Safety is constantly seeking outlets for its slogans and other messages on safe driving. At the beginning of the school season the department issued ten brief reminders prepared for announcing over college and school public address systems in the hope that such announcements will help cut traffic tragedies.

Here is an example of one of the safety messages, prepared for announcing at a football game:

"A football star plays the game according to the rules . . . that's how he became a star. You can give a star performance by heeding the rules of the road on your way home tonight. This message from your Highway Safety Department, who asks you to drive safely and fasten your safety belts."

Persons interested in obtaining the latest literature on safety are invited to contact Warren C. Nelson, Director, Ohio Department of Highway Safety, 940 Parsons Avenue, Columbus 43205.



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Clinical & Scientific Features







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Viewpoints

A Summary of a Symposium on Counseling the Cardiac on Work and Sex*

ROBERT M. LEVENSON, M.D.
Clinical Associate Professor of Medicine
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WHILE I AM CLEARLY on the side of encouraging cardiac patients to be physically active during their rehabilitation, I believe that physicians must realize that not all postinfarct patients should be part of an exercise program. There are situations where physical activity or conditioning programs may not be warranted or valuable.

The value of an exercise testing procedure is that it gives the physician an opportunity to observe the performance of the patient and to determine the nature of his symptoms, whether they are related to his heart or due to another disorder. It also enables him to evaluate the functional capacity of the patient (Class 1, 2, or 3, based on the New York Heart Association classification).

The exercise test should be a simple one and should involve an activity that is familiar to the patient; for example, walking or climbing stairs. The test should allow the physician to make simple measurements (pulse and ECG are basic); and it should be a graded one, so that the work loads are reproducible, and therefore, changes can be determined by repeat testing.

There is the classic Master's Test. It may be used as a means of evaluating functional capacity, and not just a method for looking for ST segment changes on the electrocardiogram.

I strongly favor the treadmill because it involves a simple procedure—walking—and it can be graded. (Both the elevation and the speed can be varied.)

The important factor, however, in any exercise testing is that the physician should be directly

*Held at Riverside Methodist Hospital in Columbus on December 3, 1970.

Reprinted from the pamphlet prepared by Wallace Pharmaceuticals, Cranbury, N.J. The seminar "Counseling the Cardiac on Work and Sex," was made possible by a grant from Wallace Pharmaceuticals. This was the 74th in the Company's series of postgraduate hospital seminars.
Submitted May 22, 1970.

involved and he should observe the manner in which the patient performs. The patient should be monitored and, at the least, his blood pressure and pulse should be recorded before and after the exercise. (This can be done during a treadmill or bicycle test.) In view of some recent experiences, a defibrillator and appropriate drugs (lidocaine, atropine, sodium bicarbonate) must be on hand.

In my experience, many patients develop some rather nonspecific chest pains after a myocardial infarction. Exercise testing provides an opportunity to distinguish between cardiac pain and pain that may be of musculoskeletal origin. It also allows the physician to observe the degree of dyspnea that the patient develops. Often an anxious patient may have dyspnea which is more related to emotional concern about activity than to physical effort. This can be determined by watching the patient perform.

The development of arrhythmias is an important consideration, and occasionally a patient will develop fairly serious arrhythmias while being exercised. In my clinical work with about 2,000 patients, I have had some patients develop supraventricular tachycardias, and premature ventricular contractions.

We may discontinue testing of a patient because of frequent premature ventricular beats, but not on the basis of ST segment changes alone. Usually symptoms will arise after ST changes appear within 30 or 40 seconds; and I regard the symptoms as more important than the presence of some changes in the electrical test.

A patient who is receiving digitalis may show electrocardiographic changes while being tested which are unrelated to symptoms. Presumably these are due to some changes in the muscle metabolism caused by the digitalis.

At a conference sponsored by the American Heart Association, the President's Council on Physical Fitness, and the South Carolina Heart Association, in 1969, it was generally agreed that the program for rehabilitating patients with myocardial infarctions has four phases: (1) coronary care unit; (2) recovery in the hospital; (3) convalescence at home; and (4) the resumption of normal activities.

We were concerned with a number of stage-by-stage factors—for example, how long is the patient kept in each phase; how do we determine the transition from phase to phase; and what kind of activities can the patient be advised to perform in these various phases?

Based on the concept of metabolic units or METS (one MET is the amount of oxygen used at rest and equals about 1.1 calories), the patient in the coronary care unit would have a very low level of activity—about 2 METS. During the later hospitalization period of two to three weeks, he may be permitted a 4 MET level of activity; and a 6 MET level may be allowed while convalescing at home. Ultimately, by the 12th week, the patient presumably can return to work, depending on the kind and degree of heart disease he has.

The Conference did make an effort to establish some fairly simple measurements and observations for the transition of the patient from one phase to another. It was finally felt that if a patient did not develop pain, or significant dyspnea or a pulse rate of over 120 beats per minute during low-level activity (walking in his room), then he could be moved to phase 2.

He would be elevated to phase 3, if at the 4 MET level (walking at 3½ miles an hour on the level) he did not develop such symptoms as pain, dyspnea, arrhythmias, etc. Of course, if the patient develops symptoms at any phase of rehabilitation, he will have to remain at that level for a longer period.

In our cardiac work evaluation unit at Seattle, it has been our practice to do maximal testing on patients at the end of 12 weeks. We test them on a treadmill to the point of fatigue or of cardiac symptoms.

There are clinicians who believe that the target figure for stressing a patient should be 70 percent of the maximum pulse rate. Because maximum pulse rate to some degree is age-dependent, the physician can come close to predicting this 70 percent figure. Establishing this pulse as the maximum to be achieved on any activity may very well be the best means of establishing exercise and energy output limits on a patient who has recovered from a myocardial infarction.

Ray H. Rosenman, M.D.
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IN ORDER TO RESTORE the postcoronary patient to a productive life, the physician must make an effort to understand the psychologic as well as the physiologic aspects of the problem. He should determine the patient's needs and resources, and assess the history of the patient thoroughly — family, sexual, educational, vocational, and economic status. Knowledge of the patient's personality, emotional patterns, and precipitating stresses is essential.

The younger and middle-aged coronary victim often can be characterized in terms of his background. His adult life has included marriage, children, advancement in job and social status, and usually some increases in weight, smoking, blood pressure, and serum lipids. Because of less

exercise, his physical fitness declines, and often his sexual activity also decreases. The typical victim also exhibits certain personality traits, such as enhanced aggressiveness, competitiveness, ambitiousness, some hostility, and a sense of time urgency. He is often impatient, unable to relax, and seeks to dominate at work and at home.

Medical researchers have found a remarkable unity in the *in toto* characterization of the premorbid personality of the younger and middle-aged coronary-prone victim.

This type of individual exhibits characteristics which are really quite independent of his occupation, education, and socio-economic status. Our research group describes this coronary-prone individual as "behavior pattern type A." The man without these various enhanced traits would be type B.

There is good evidence that the habitual excess diet and physical inactivity that prevail in Western culture, in conjunction with the increasing exhibition of type-A behavior, are responsible for our recent sharp rise in coronary morbidity.

In our study of 3,500 men, we found that type A men suffered a statistically higher incidence of coronary disease, two to three times greater than type B. If type A men exhibit some other so-called coronary risk factor, for example, higher serum cholesterol, the incidence of coronary disease is particularly high. The type A group also had a much higher rate of recurring infarction, fivefold higher than type B men.

Although personality traits are difficult to change, since they may partly be present even from birth, the physician should have repeated discussions with the patient to help him slow down and to eliminate unnecessary involvements and other typical behavioral excesses. Our own experience has shown that if a physician takes the time to do this, he will reduce the frequency of recurring coronary events.

A careful history of the patient often reveals that acute infarction occurred after a time of mounting emotional stress. Such a history also often points up a double-conflict situation—a conflict, not only at work but simultaneously one at home or in the community. During the more immediate premorbid period, there is often a history of acute stress. The individual often becomes the central figure in some emotionally invested deadlines or loss of prestige, loss of income, diminished libido, and occasionally a real personality deterioration occurs.

Now, if the physician gives the patient a chance to talk and pays attention and listens to the patient as a human being, he will be able to help the patient in his recovery.

Heart attack induces an onslaught of anxiety, even in the most stable person, and the required immediate passive posture often compounds this anxiety. When the patient arrives at the hospital he becomes the center of many activities that are incomprehensible to him. He is usually denied verbal communication, and a passive attitude is enforced. This is especially difficult for a person who is a hard worker and who is motor active.

If the patient is in the coronary care unit and if electrical therapy or pacemakers are required, the emotional trauma is considerably enhanced.

Attention to this early anxiety is most important, since the body response is an adrenergic excess that may have major somatic repercussions in the heart rate, blood pressure, ischemia of the myocardium, etc.

The initial acute anxiety may be followed by a chronic form, and the physician should use every means to prevent this. Psychotropic drugs are extremely useful during the acute hospital period to allay anxiety and later to diminish emotional hyperactivity, and certainly they improve the patient's outlook on life. The reaction of excessive anxiety or more destructive behavior should require the attention of a psychiatrist.

Later, when a patient returns to the family, he is often returning to an environmental situation which very possibly might have played a precipitating role in the coronary attack. I urge the physician to investigate the family setting of the patient.

The physician should encourage the physical rehabilitation of the patient as early as is feasible during the postinfarction period.

The program for conditioning the patient, however, should be on the conservative side. The patient may walk slowly, at a rate of about one to two miles an hour for short periods in the room by the tenth day, providing he does not show evidence of shock, serious ventricular arrhythmias, or uncompensated congestive heart failure. By the end of the fourth week, many patients can walk slowly in the corridors every two hours. The rate and duration of these slow walks should be increased slowly. The program will be more rewarding if there is group participation.

Exercise should be sufficient to generate a heat load but should not be intense enough to induce a heart rate over 150 beats per minute.

The patient must be taught to avoid signs which indicate that he has exceeded 50 to 60 percent of his maximum aerobic capacity. These signs include a heart rate over 150, excessive shortness of breath, profuse sweating. In addition, the patient may notice angina, particularly the day after the exercise session. Rarely in a physical conditioning program, however, do you encounter a serious event or a mortality.

The return to sexual activity rates very high

in the order of rehabilitation, because the self-image of the postinfarction patient is threatened —as the man of the family and as head of the family. The physician should anticipate the patient's fears and explain to him why he should avoid the stresses of sexual or other physical activity during the first several months of recovery. If the patient can perform exercise at a level of 6 calories per minute, as in brisk walking, it is safe for him to return to work and to sexual activity.

Generally, it has been found that sexual activity accounts for less than one percent of sudden deaths. Moreover, the very few coition deaths caused by coronary disease have usually occurred after extramarital intercourse, and more rarely in conjugal activity.

The actual physiologic cost of sexual activity is far less than we once believed. It is about equivalent to that of climbing one flight of stairs at a medium pace or walking rather briskly. At the peak of sexual intercourse, during the orgasm, the heart rate will usually average between 120 and 140 beats per minute in most of a group of post-infarction patients. However, one minute before the orgasm and one or two minutes after, the heart beat is surprisingly low—about 100 or less.

Sexual activity is often improved in both quality and quantity by physical conditioning programs. Of course, physical fitness is influenced not only by the degree of damage in the heart, but also by the lack of premorbid conditioning, and by prolonged convalescence, overweight, other illness and emotional factors.

The physician must direct therapy not only at the cardiovascular system, but also at the total patient and his environment. Accordingly, the therapeutic program must be individualized.

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THERE IS GENERAL AGREEMENT that anxious and nervous cardiac patients do have complicated and prolonged illnesses, often with delayed convalescence.

In an effort to understand some of the management problems which confront the physician in the treatment of the chronically ill cardiac patient, our research group made an evaluation of anxiety and the effects of illness in 100 consecutively admitted general inpatients. (Twenty of them had diagnosed heart disease.)

We found that none of the conventional methods for testing anxiety differentiated the cardiac group from the noncardiac patients; in fact, the scores were remarkably similar. Therefore, it appears that these scales have little value for obtaining a better understanding of the cardiac patient's emotional distress.

One psychosomatic hypothesis suggests that these patients do not express anxiety overtly, and that the effects of their suppressed anxiety contribute to the development of lesions in the cardiovascular system.

In another evaluation, attending physicians and nurses rated the cardiac patients as having significantly less emotional illness and less anxiety and tension than the other patients. For example, on a checklist of attitudes and behavior, the nurses noted that the cardiac patients were more cheerful and socialized better than the other patients.

The failure of attending physicians and nurses on a busy medical inpatient service to detect the anxieties and fears of the cardiacs reflects the stereotyped belief that anxiety is present only when the patients exhibit conventional signs of it.

In-depth interviews, however, with the cardiac patients revealed that they were significantly more frightened by their illness than were the other patients. Twelve (60 percent) of them display moderate to extreme fear-fright, compared with 25 percent of the others.

The quality of the cardiac patient's anxiety was characterized by pervasive inner fear; indeed, a sense of dread and fright, which was unveiled only when the patient was directly questioned about it.

The discrepancies in these various evaluations point clearly to a clinical problem. I think that the cardiac patient's persistent fear-fright, veiled by cheerfulness, really has an inimical influence on the illness and on the management of the patient.

We concluded from our studies that patients should be questioned directly about their feelings of fear and fright, and that physicians should be aware of their patients in these terms.

According to our interview data, the cardiac patients expressed much more concern that their illness would affect their total life situation to a greater extent than the noncardiac patients did. They felt their illness would have an adverse effect on their work, their finances, and their sex life, which was one of the most significant findings of the study. However, they reported positive effects on their religious life and increased harmony within the family.

A bout of heart failure or the diagnosis of heart disease, such as angina, and particularly a myocardial infarction, produces definite changes in most patients' and their families' modes of living. Counseling a patient about sexual activity

is beneficial only when it is related to the quality of his previous sexual adjustment and to personality conflicts; that is, the totality of the patient and his family's existence.

Most postcoronary patients voluntarily reduce their sexual activities; and this may be adjustive, particularly if they can glean pleasure from other facets of their lives. It is surprising how many of these patients, especially the work-oriented, ambitious ones, have never taken the time for hobbies, recreation, or travel.

A major factor is that cardiac patients wish to avoid excessive excitement; they are afraid of it. In general, they tend to avoid conflicts at work and tension when driving, as well as sexual stimulation. They often admit to fears that sex will damage their heart. In fact, we have observed that the excitement of sexuality is feared by cardiac patients more than physical exertion.

Generally, for the great majority of cardiac patients, sexual activity per se does not become a problem of overriding importance, particularly when the physician helps the patient and his wife place it in proper perspective.

In cases where sexual activity or the absence of it becomes an overwhelming problem, we are dealing with emotionally disturbed persons whose problems preceded the onset of the heart disease and are compounded by its stress.

Two distinctive types of psychopathology can be observed in cardiac patients. The first is the development of successive phobias to the extent that the patient is fearful of almost any physical activity—work, new situations, and sex.

Many of these patients become helpless, dependent invalids who withdraw from life and exist only in the confines of their home or under the protection of a physician's office or the hospital. Often, it appears that the technologic benefits of a coronary care unit reinforce, if not expand, the fears of these patients.

In the second type of psychopathology, the patient engages in a variety of counterphobic activities. He attempts to prove to himself and others that medical restrictions, particularly those pertaining to work and sex, can be exceeded with impunity. In extreme cases the illness may be denied and medical advice completely ignored.

Most physicians are able to treat successfully the milder cases in these two categories by enlitsing the help of the family and by using clearly stated explanations. These rational approaches are insufficient, however, for the patient whose basic death anxiety has been a significant feature throughout his life, and for the "super-doer," who dismisses their logic.

Such patients require psychiatric treatment. The referral procedure can be therapeutic if the physician confronts the patient and his family with the facts—not hedged, nor excused, not glossed over—that psychiatric assistance is mandatory.

Psychotherapy is a primary element in the comprehensive treatment program of cardiac patients, and a great majority of these patients can be cared for successfully by physicians, especially if they devote time to discussing fear and fright openly with them.

Medication is another element of importance. We have found that states of anxiety are so common that anti-anxiety medications, such as meprobamate, are generally indicated.

ELECTRIC AVERSION was administered to 14 cigarette smokers. Six of the nine who completed the treatment were still abstinent at one-year follow-up. Three cases relapsed (at one, three, and four months) and five dropped out of treatment. Depression was a troublesome side-effect and was responsible for two of the drop-outs. The overall average of 21.5 cigarettes on the day before treatment dropped to an average of 1.4 cigarettes per day after the third aversion session, and though individual response varied widely most patients stopped smoking within five sessions. It is concluded that electric aversion is a powerful suppressor of cigarette smoking, but more experience is needed to ensure its best use as a measure to achieve permanent abstinence. Its use is limited to a small group of well-motivated smokers.—M. A. Hamilton Russell, M.R.C.P., London: *British Medical Journal,* 1:82-86, January 10, 1970.

The Role of Prostaglandins in Reproductive Physiology

Tom P. Barden, M.D.

THE GROUP OF SUBSTANCES known as the prostaglandins have a history which dates back to 1930 when Kurzrok and Lieb,[1] two New York gynecologists, observed that human seminal fluid caused relaxation of isolated uterine strips from fertile patients and it caused stimulation of specimens from women with a history of infertility. A few years later Goldblatt,[2,3] in England, described a depressor action of human seminal fluid on blood pressure and motility of certain isolated organs. U.S. von Euler,[4,5] in Sweden, independently observed strong smooth muscle stimulating activity of human seminal fluid as well as seminal fluid of the monkey, sheep, and goat. He prepared lipid extracts of vesicular glands and found the activity associated with a fraction containing lipid-soluble acids. Further studies indicated that the substance contained a double bond, and its solubility properties indicated it to be a hydroxy acid.[6]

During the subsequent two decades, 1940 to 1960, additional investigation of prostaglandin was virtually abandoned. In 1956, the Upjohn Company financed the collection of several tons of sheep seminal vesicles from Norway and Iceland for subsequent studies at the Karolinska Institute. In 1960, Bergstrom and Sjovall,[7,8] using extracts from sheep vesicular glands, isolated active compounds in crystalline form which were designated prostaglandin E (PGE) and prostaglandin F (PGF). This work was soon followed by other isolations using vesicular glands of sheep for biosynthetic preparation of prostaglandins. At present, no less than 16 different prostaglandins have been isolated, and all of these unsaturated hydroxy fatty acids with a 5-membered ring on a 20-carbon skeleton are derivatives of a 20-carbon parent substance called prostanoic acid. Figure 1 illustrates some of the prostaglandins and their precursors. All except $PGF_{3\alpha}$ have been identified in human seminal plasma.

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Evidence is rapidly accruing that prostaglandins enjoy a near ubiquitous existence in human tissues. Although prostaglandins are found in large amounts in human seminal vesicles and vesicular glands of sheep and goats, they have not been identified in corresponding glands from other animals such as the horse, bull, dog, rabbit, cat, and other laboratory animals.[9] Eliasson[10] used the split-ejaculation technic to demonstrate that prostaglandins are formed in the vesicular gland rather than the prostate. Human seminal plasma contains about 50 μg per ml of PGE compounds, 8 μg per ml of PGF compounds, 50 μg per ml of PGA and PGB compounds combined, and 200 μg per ml of 19-hydroxy prostaglandins.[11-13]

Investigation of the physiologic or pathologic roles of prostaglandins in various organ systems is hindered by lack of sensitivity of assay methods and by the fact that in vitro responses are observed at concentrations less than 1 μg per ml, and in vivo at less than 1 μg per Kg. This extreme potency of prostaglandins on a variety of tissues has led many to consider them hormones.

In general, the PGE series, studied in vitro, act to decrease the motility of the human uterus, fallopian tubes, and ureter, and they produce

vasodilatation; while the PGF's cause increased motility of the uterus, fallopian tubes, ureter, and gastrointestinal muscle, and vasoconstriction. Prostaglandins have also been found to inhibit lipolysis, platelet aggregation, and gastric secretion.[14] In studies of tracheal smooth muscle, PGE produced inhibitory responses.[15] Lipolysis induced by catecholamines, corticotropin, glucagon, thyroid-stimulating hormone, vasopressin, sympathetic nerve stimulation, and cold stress are all reduced in the presence of low concentrations of prostaglandin E_1.[16] In vitro studies of human adipose tissue have also demonstrated inhibition of lipolysis by PGE_1.[17] In contrast to in vitro studies, injection of PGE_1 in human volunteers induces lipolysis in doses lower than those with inhibitory action on the lipolytic action of other hormones.[18,19] Prostaglandins are present in brain, spinal cord, and cerebrospinal fluid. To date their exact role in the nervous system has not been clarified.

Although the exact mechanism of action for prostaglandin compounds has not been fully elucidated, there is growing evidence that many responses are due to interference with the enzyme adenyl cyclase, which catalyzes the formation of adenosine 3′, 5′-monophosphate (cyclic AMP) from adenosine triphosphate. Lipolysis, steroidogenesis, gastric secretion, certain smooth muscle motility responses, and increase in permeability due to vasopressin have all been found to be mediated by the adenyl cyclase-cyclic AMP system.[16] In most instances the actions of PGE_1 can be explained on a basis of a nonspecific inhibition of adenyl cyclase.

Early studies of the responses of myometrium to prostaglandin by Bygdeman and Eliasson[20] and Bygdeman[21] revealed that PGE_1, PGE_2, and PGE_3 all inhibited the motility of human myometrium in vitro while $PGF_{1\alpha}$ and $PGF_{2\alpha}$ produced mixed responses. In contrast, Pickles and associates[22,23] found $PGF_{2\alpha}$ consistently stimulated human myometrium, but PGE_2 caused a variety of responses. Human pregnant myometrium was studied in vitro by Embrey and Morrison,[24] who found upper segment myometrium more responsive than lower segment specimens and stimulatory effects by PGE_1 and PGE_2 as well as $PGF_{1\alpha}$ and $PGF_{2\alpha}$. Bygdeman and coworkers[25] reported PGE_1 in a low dose, 0.01 μg per ml bath fluid, gave a marked increase in tone and amplitude of contractions, while a higher dose, 0.03 μg per ml, resulted in inhibition of the motility. These same workers studied the effects of PGE_1 and PGE_2 on the motility of the pregnant human uterus in vivo and reported that doses of 2 μg per minute, intravenously, invariably resulted in stimulation of tone and amplitude of contractions. They further reported a more marked response of hypertonus from intravenous infusion of PGE_1 and PGE_2 during mid-pregnancy in contrast to studies of subjects near term. They concluded that PGE compounds do not appear suitable for induction of labor due to occasional unphysiologic elevations of tone. The influence of intravenous injections of PGE_2 was compared with that of PGE_1 and found to be approximately the same both qualitatively and quantitatively.

Embrey[26] studied PGE and PGF compounds in both early and late pregnancy, and in the same dose range (2-6 μg per minute to maximum dose of 200 μg) as in the experiments of Bygdeman and co-workers. Both noted a 15 to 20 minute latent interval between institution of intravenous infusion of the prostaglandin compound and the initial uterine response. Embrey also described an increase of tonus as the dominant effect of PGE_2 in early pregnancy studies. In eight studies of PGE_2 in term human pregnancy, Embrey observed a consistent response of increase in frequency and amplitude of contractions. A single instance of hypertonus in this series of experiments promptly resolved when the intravenous infusion rate was reduced. In the studies of both Bygdeman and associates and Embrey, the uterine responsiveness to prostaglandins was essentially unchanged from mid-pregnancy to term. In both studies, the intravenous infusion of prostaglandins in the dose range studied did not result in subjective side effects, changes in heart rate, alterations of blood pressure, or detectable fetal responses.

Karim[27] reported the appearance of $PGF_{2\alpha}$ in the blood of pregnant women at the onset of labor, and higher levels of $PGF_{2\alpha}$ in blood taken during second stage labor than samples obtained during the first stage. Detectable concentrations of prostaglandins were usually absent by three hours postpartum. Karim[28] and Karim and Devlin[29] also reported that $PGF_{2\alpha}$ is present in human amniotic fluid obtained during labor.

In a recent report,[30] Karim and associates describe the results of induction of labor with $PGF_{2\alpha}$ in 35 women at or near term. In 29 cases out of 35, labor was successfully induced with a single intravenous infusion of $PGF_{2\alpha}$ approximately 2 μg per minute for from 1 to 11½ hours. A latent period of approximately 20 minutes from the onset of the infusion to the first contraction was generally observed. Uterine activity gradually increased by virtue of increased frequency of contractions, a lesser degree of increasing amplitude of contractions, and no change in uterine tonus. The average infusion to delivery interval was nine hours, 35 minutes. No instance of fetal distress or adverse fetal response during or after the infusion of prostaglandin was described. There were also no alterations of maternal cardiovascular signs during or after the $PGF_{2\alpha}$ infusions. Karim and

Filshie[31] also recently reported on the use of $PGF_{2\alpha}$ in 15 patients recommended for therapeutic abortion. With an intravenous infusion of 50 μg $PGF_{2\alpha}$ per minute, an initial period of hypertonus was followed by labor-like uterine contractions. Fourteen of the 15 women progressed to abortion in an average of approximately ten hours. The only apparent side effect was diarrhea in about half of the patients.

Thus the role of $PGF_{2\alpha}$ in parturition has not been clarified; however, early evidence indicates the potential role of $PGF_{2\alpha}$ as an oxytocic, apparently more useful than synthetic oxytocin in cases of therapeutic abortion, when the early pregnancy uterus is relatively insensitive to oxytocin.

Another interesting area of prostaglandin research concerns the potential role of these compounds in treatment of human infertility. Karlson,[32] in 1959, described an increased motility in the corpus and decreased activity in the isthmus and cervix following instillation of human semen in the posterior fornix of the vagina. Eliasson and Posse[33] used a partially purified prostaglandin extract from human semen to study the uterine motility following vaginal instillation in nonpregnant women. They reported stimulation of activity in the corpus at the estimated time of ovulation, in contrast to variable responses during other periods of the menstrual cycle. They further reported consistent inhibition of uterine motility at the presumed time of ovulation when the instillation of the seminal extract was accompanied by a slow intravenous infusion of oxytocin and vasopressin. On a basis of these and other studies, Eliasson[10] stated the hypothesis that the physiologic role of prostaglandin in seminal fluid was to facilitate the migration of spermatozoa from the vagina into the uterine cavity.

Sandberg and co-workers[34] studied the vaginal absorption of tritium labelled PGE_1 from the posterior fornix of seven normal menstruating volunteers. They found that 10 to 25 percent of the radioactivity administered was recovered in the urine within 24 to 32 hours. Previously the work of Hansson and Samuelsson[35] established that radio-labelled PGE_1 is taken up moderately well from the blood by tissues of the female reproductive tract in mice. The relaxing effects of PGE_1 on myometrium, seen during in vitro studies, has thus been hypothesized by several investigators as possibly responsible for a suction-like effect as seminal fluid is drawn through the canal of the cervix. Bergstrom, Bygdeman, and Samuelsson, at the Karolinska Institute, have found that some infertile males have low prostaglandin levels in their ejaculate, and they are working with methods of improving the levels to improve fertility.[36]

A potential role of prostaglandins in the etiology of dysmenorrhea has been proposed by the work of Pickles[37] in which he measured prostaglandin levels in virtually all menstrual fluid during 19 menstrual cycles of a girl 14 to 16 years old. Using basal body temperature graphs as an indication of ovulation, he found the levels of prostaglandins, predominantly $PGF_{2\alpha}$, decreased during presumably anovulatory cycles. Pickles and co-workers[23] also reported a significantly higher ratio of PGF to PGE in a series of patients with severe dysmenorrhea than in a comparable series of normal patients.

A further area of very exciting research of prostaglandins involves the luteolytic properties of $PGF_{2\alpha}$. The physiologic mechanism of regression of the corpus luteum when pregnancy does not occur has not been clearly established. There is evidence in several species that a bloodborne factor from the uterus may be in part responsible for this phenomenon. In species with a bicornuate uterus, if only one horn is removed, the corpora lutea on that side persist, while those in the contralateral ovary, adjacent to the remaining horn, regress in the usual manner.[38] The role of the uterus in release of $PGF_{2\alpha}$ is possibly supported by the work of Fischer,[39] who found that the corpus luteum persists longer than usual when hysterectomy is performed during the early luteal stage of the menstrual cycle. Pharriss and others[40,41] have developed the hypothesis that $PGF_{2\alpha}$ released from the uterus acts on the ovarian veins by constriction and thus produces relative ovarian ischemia, which in turn interrupts normal ovarian metabolism resulting in regression of the corpus luteum. The theory was supported by the study of Pharriss and Wyngarden[42] in which daily injection of $PGF_{2\alpha}$ shortened the time of pseudopregnancy in rats from an average of 17 to 8 days.

Gutknecht, Cornette, and Pharriss[43] reported $PGF_{2\alpha}$ uniformly effective in terminating early pregnancy in rats and rabbits given subcutaneous injections for a 3 to 5 day period during the first two weeks after conception. Administration of exogenous progesterone (medroxy progesterone acetate) protected rats against the antifertility action of $PGF_{2\alpha}$. Kirton and co-workers[44] studied the antinidatory effects of $PGF_{2\alpha}$ in a group of rhesus monkeys. Following mating, pregnancy was presumptively diagnosed by increasing blood progestin levels typical of the species. Monkeys treated with $PGF_{2\alpha}$ on days 11 through 15 after mating had a fertility rate of only one of six treated animals in contrast to a fertility rate of six fertile of ten control matings. Thus the potential use of $PGF_{2\alpha}$ as an antinidatory treatment is becoming established.

A further potential role of prostaglandins in reproductive physiology and pathology is emerging from investigations of their actions on fallopian tubes. It is generally agreed that the oviduct has

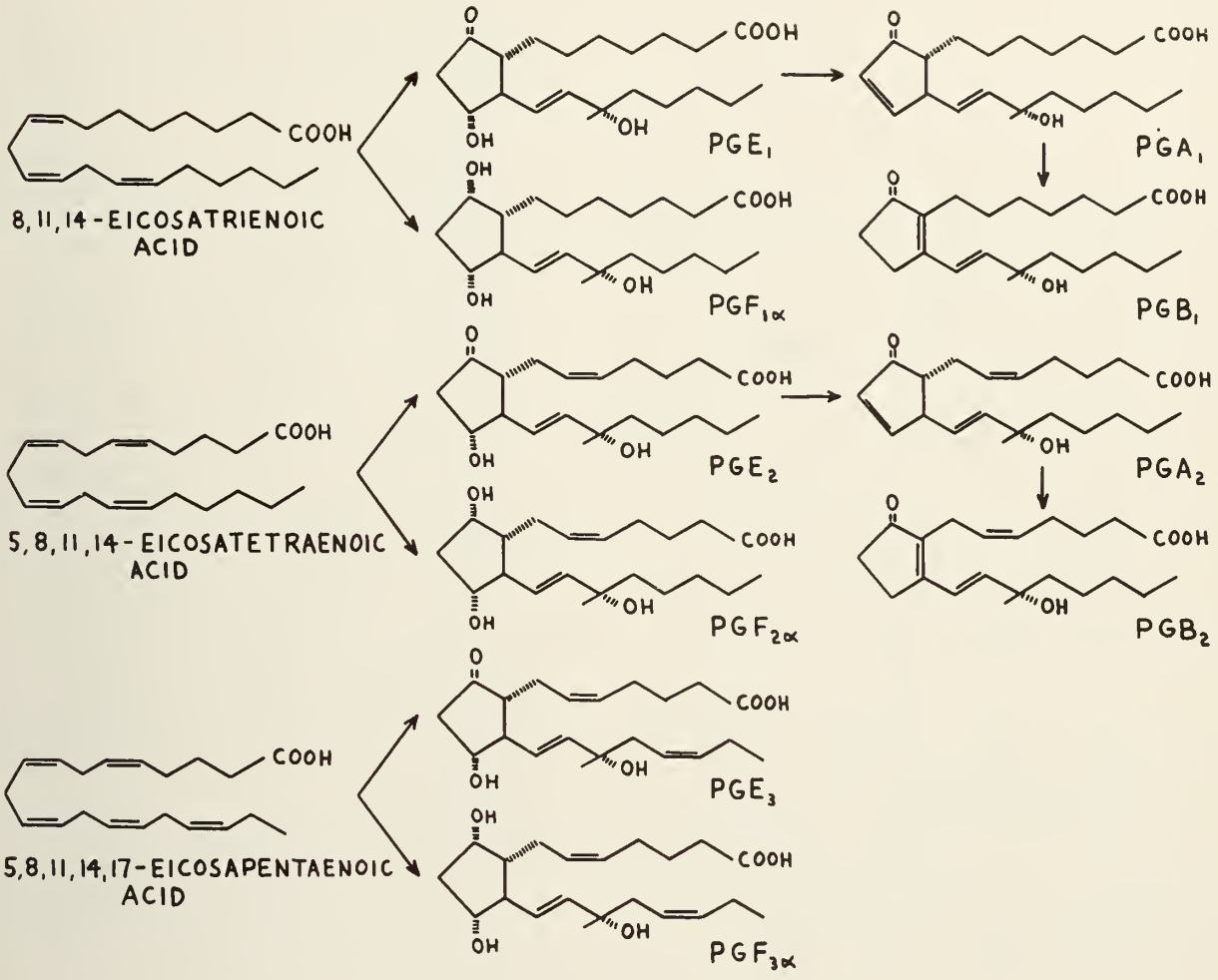


FIG. 1. Prostaglandins and their precursors.

regional patterns of contractility which may be responsible for the three day residence of the fertilized ovum within the fallopian tube prior to implantation in the uterus. Sandberg, Ingelman-Sundberg, and Ryden, in a series of reports,[45-47] described the ability of PGE_1 and PGE_2 to constrict the proximal, or uterine end and to relax the distal portion of the human fallopian tube in vitro. This difference between the first portion and remainder of the tube was most pronounced in the secretory phase. PGE_2 inhibited all tubal segments in both secretory and proliferative phase, while PGF's caused constriction of all segments regardless of menstrual phase. The potential role of various prostaglandins in treatment of infertility and perhaps as nonsteroidal contraceptives requires further investigation.

The physiologic role of various prostaglandins is gradually being elucidated while pharmacologic actions suggest a variety of therapeutic applications. In reproductive medicine, prostaglandins have been implicated in sperm transport mechanisms, menstruation, parturition, and control of uterine, ovarian, and placental blood flow.

Summary

The biochemical nature and physiopathologic roles of prostaglandins have been reviewed as related to reproductive medicine. These compounds have been implicated in uterine motility related to sperm transport, menstruation, and labor; lysis of the corpus luteum; and fallopian tube motility. From a therapeutic viewpoint, potential applications of prostaglandins have been suggested in the induction of labor, treatment of infertility, "morning-after" contraception, treatment of dysmenor-

rhea, and contraception by alteration of fallopian tube motility.

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Circulating Anticoagulants as a Cause of Postpartum Hemorrhage

Case Report

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CIRCULATING ANTICOAGULANTS are a rare and unusual cause of postpartum hemorrhage. In 1940, Lozner, Jolliffe, and Taylor presented the first documented case of hemorrhagic diathesis associated with circulating anticoagulants which inhibited the coagulation of normal blood.[9] Since the original description, circulating anticoagulants have been described in three types of patients (A) patients with classic hemophilia who have received multiple transfusions,[15] (B) postpartum patients who develop a hemorrhagic disorder resembling hemophilia,[1-7, 10-13] and (C) individuals in whom hemophilia-like disease appears without previous transfusions, pregnancy, or family history of bleeding tendencies.[16] The purpose of this paper is to present the case of a postpartum patient with a first stage coagulation defect where circulating anticoagulants were suspected. A brief discussion of this unusual form of coagulopathy is presented.

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Case Report

The patient is a 23-year-old, white female, gravida 1, para 1, whose last menstrual period was March, 1966. She had been taking birth control pills (mestranol 80 mcg. plus chlormadinone acetate 2 mg.) for approximately nine months. When she failed to have withdrawal bleeding in April and May of 1966, pregnancy was confirmed. Her pregnancy was uncomplicated except for mild ankle and hand swelling which responded to chlorothiazide therapy. On January 10, 1967, she delivered a term infant under pudenal and Trilene anesthesia over a midline episiotomy without complications. Immediately after delivery, the patient received an injection of Deladumone (testosterone enanthate and estradiol valerate) to control postpartum breast engorgement and lactation. She was discharged four days later without complications. Eight days after delivery, she started to have heavy, bright red vaginal bleeding and was readmitted to her local hospital the following day. Treatment consisted of four units of whole blood and later a uterine dilatation and curettage (D & C) on the 14th postpartum day. At the time of the D & C, minimal tissue was obtained. After the D & C, the patient received two more units of blood and was discharged from the hospital. Five days later the bleeding recurred. Twenty-two days postpartum, she was readmitted

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to the hospital because of bleeding and a hemoglobin level of 8.3 gm per 100 ml. Her local physician had only two units of type specific blood and she was bleeding fairly briskly at this time, so she was given one unit of blood, 20 mg. Premarin intravenously, 25 mg. Solu Cortef intramuscularly and fibrinogen in spite of a normal fibrinogen index. She was then transferred to The Ohio State University Hospitals. Upon arrival in the emergency room, the patient was complaining of lightheadedness, and she appeared quite pale. Blood pressure was 85/60 mm. Hg. and the pulse rate 120 beats per minute. Pelvic examination revealed 300 cc. of clotted blood in the vagina. A 3-cm. organized hematoma on the lateral vaginal wall was noted. The cervix was dilated to about 1 cm. and the uterus was three months in size. The patient was stabilized with one unit of dextran and two units of blood, and she was taken directly to the operating room where a second D & C was performed. No uterine, cervical, or vaginal lacerations were found. Again, minimal tissue was obtained. Postoperatively, she was given two more units of blood which brought her hemoglobin level to 12.9 gm. per 100 ml. and hematocrit value to 39 percent. She was maintained on bedrest, Pitocin drip, and Ergotrate for the next several days, and the bleeding stopped. On the fifth postoperative day, the patient was ambulated and again began to bleed vaginally. Consultation was obtained with the hematology service and, from the results of the coagulation studies, it was concluded that the patient had a coagulation defect and that the defect was most likely due to the presence of circulating anticoagulants.

Over the next 11 days, the patient was treated with bed rest, Ergotrate, and Ferrous gluconate, and the bleeding gradually decreased. The patient was started on Deluteval 2x (hydroxyprogesterone caproate and estradiol caproate) for contraception and to maintain amenorrhea, and she was discharged on the 18th hospital day. She was seen again in six weeks, she was found to still have an abnormal partial-thromboplastin time; however, at eight months this had returned to normal.

Laboratory Studies

While in The Ohio State University Hospital, the laboratory studies supporting the diagnosis of circulating anticoagulants were as follows: Bleeding time, 1 minute, 54 seconds; Lee-White clotting time 21 minutes and 25 seconds (normal 8 to 12 minutes) and clot retraction of two hours; partial thromboplastin time, 127.5 seconds (control 73.4 seconds); one stage prothrombin consumption time, 15.8 seconds (control 58.8 seconds); and platelet count 311,000 per cu. mm. (normal 150,000 to 450,000 per cu. mm.). The fibrinogen screen was normal, and the test for fibrinolysin was normal (clot was unlysed after three hours at 37 C). Prothrombin time was 60 percent. The partial thromboplastin time was repeated using a 1:1 substitution technique with 0.5 cc. of the patients plasma for 0.5 cc. of normal plasma. The result was 101 seconds constituting a marked prolongation of the partial thromboplastin time.

From the laboratory data, it is readily apparent that this patient had a first-stage coagulation defect. The fact that the partial thromboplastin time did not improve when 50 percent normal plasma was substituted for 50 percent of the patient's plasma indicated an interference by the presence of circulating anticoagulants with the thromboplastin activity. The increased thromboplastin time confirmed the diagnosis, as any genetic defect likely to be confused with it would have been corrected by the addition of 50 percent normal plasma.[8]

Discussion

Circulating anticoagulants are defined as abnormal endogenous components of blood which inhibit coagulation of normal blood.[3] They are protein in nature and are found in the gamma globulin fraction of serum, [4,11] The coagulation defect is brought about by the formation of an antibody to one of the blood factors necessary for the first stage of coagulation. The usual factor involved is AHF (factor VIII), although other coagulation factors have been implicated.[11] It is theorized without proof, that perhaps the fetus has a blood factor which is slightly different antigenically from the mother but similar enough that the resulting antibodies react with one of the mother's clotting factors so that normal coagulation does not occur.[4] This depletion of one of the blood factors of coagulation (i.e. factor VIII) may result in a hemorrhagic disorder similar to hemophilia.[11] The bleeding tendency is usually abrupt and severe with ecchymosis, soft tissue bleeding, hematuria, hemarthosis, menometrorrhagia, hematomas, epistaxis, and gastrointestinal bleeding. This bleeding diathesis usually occurs within the first two to three months postpartum and may persist for several months to years with several deaths having been reported in the literature.[11]

First stage anticoagulant defects can be detected with a partial thromboplastin time, thromboplastin generation time, and specific factor assays. If an abnormality is found, one should suspect a circulating anticoagulant. Circulating anticoagulants have been demonstrated in the blood of an infant born to a woman whose blood contained anticoagulant activity.[17]

Despite the serious nature of the bleeding in women with circulating anticoagulant developing

after childbirth, only a few patients are known to have died of this disorder.[14] Although the anticoagulant may persist for many years, it has disappeared spontaneously from the blood of a number of patients after intervals ranging from six months to 11 years after the first symptoms of bleeding had appeared.[18]

Summary

This is the report of a case of a hemorrhagic disorder resembling hemophilia developing in the postpartum period. The hemorrhagic diathesis is thought due to the formation of an antibody against one of the blood factors necessary for the first stage of coagulation.

The mechanism of production of this circulating anticoagulant is briefly reviewed, and the management of the patient with this unusual form of coagulopathy is discussed.

Generic and Trade Names of Drugs

Testosterone enanthate and estradiol — Deladumone (E. R. Squibb & Sons)
Conjugated estrogens (equine) — Premarin (Ayerst Laboratories)
Hydrocortisone sodium succinate — Solu-Cortef (Upjohn Co.)
Oxytocin — Pitocin (Parke, Davis & Co.)
Ergonovine maleate — Ergotrate (Eli Lilly & Co.)
Ferrous gluconate (Eli Lilly & Co.)
Hydroxyprogesterone caproate and estradiol valerate — Deluteval 2X (E. R. Squibb & Sons)

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POLLUTION has become a global pastime. Man's ingenuity in discovering new chemicals is exceeded only by his ability to disseminate them into his environment. Practically all chemicals foreign to the human organism may act as sensitizers.

Finding and removing the cause of chemical allergy is essential in the management of the individual patient. Awareness of the possible sensitizing aspects of both hidden chemicals and new sensitizing molecules is important in aiding man to adjust to his cluttered environment.—William C. Grater, M.D., Dallas: *Southern Medical Journal,* 63:679-683, June 1970.

Circulatory Effects of Estrogen

Sheldon Kushner, M.D.

ESTROGENS ALONE and estrogens combined with progesterones in the form of oral contraceptives have had a terrific impact on medicine, obstetrics and gynecology, and our society in general. Estrogens with their effects and side effects have also been among the most controversial drugs of this decade.

Before April, 1968, there were no reports that claimed a statistically valid cause and effect relation between the oral contraceptives and the frequently reported side effects of thromboembolic disease. In fact, the Food and Drug Administration had reported in 1963 that the occurrence rate of thromboembolic disease in patients on oral contraceptives was not statistically significant.[1] A report by the Food and Drug Administration in 1966 again denied a cause and effect relationship.[2] However, two articles in the *British Medical Journal* in 1968,[3,4] indicated that there was indeed a statistical relationship between birth control pills and thromboembolic disease.

Effects of Estrogen on the Clotting Mechanism

In a report on oral contraceptives in the *British Medical Journal* in 1963, Egeberg and Owren[5] reiterated a point that had been made much earlier by Virchow[6] in the late 1800's. They stated that the factors known to predispose to thrombosis are: (1) coagulation properties of the blood; (2) changes in platelet count and platelet adhesiveness; (3) changes in the velocity of local blood flow; and (4) lesions of the vascular intima. Thus it becomes pertinent to review the effects of estrogens to learn how they might feasibly predispose to thromboembolic disease.

Thomson and Poller[7] reported a study in which 40 patients on a variety of oral contraceptives were compared to a similar group of controls and another series of patients with active thrombosis. They found an increase in factor VII activity in the patients on oral contraceptives. The levels of this coagulation factor reached their highest point during the third month of treatment. The elevation of factor VII levels was similar to that seen in pregnancy and the puerperal period. The same investigators also noted that factor VII was increased in patients with thromboembolic disease. Further, in this group they found greater factor VII activity than in patients on oral contraceptives without thromboembolic disease. These authors hasten to emphasize that the exact role of factor VII in intravascular clotting and thrombosis is uncertain. Although concerned in the extrinsic clotting system, factor VII is also generally regarded as having a role in normal hemostasis and thrombosis.

Egeberg and Owren,[5] in England, studied the effects of norethynodrel with mestranol on coagulation in a small group of women. They studied ten women aged 22 to 42 years, who had normal menstruation and who had never been on hormone therapy. Five women were given norethynodrel 5 mg and mestranol 0.075 mg daily for one cycle, and five women were not treated. The women on the drug showed an increase in antihemophilic

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factor (factor VIII) and an increase in proconvertin (factor VII). No changes in these coagulation factors were noted in the controls. The changes that occurred in the drug-treated group occurred in the first two weeks and converted to normal soon after the medications were discontinued.

Rutherford, et al[8] did a comparative study on a group of normals using no contraception, 14 pregnant women and 78 women using norethindrone 10 mg, and mestranol 0.1 mg, for contraception. They found an increase in the vitamin K-dependent clotting factors, that is, an increase in prothrombin activity, factor VII, factor IX, and factor X. Similar increases in these factors were noted in the pregnant group. They did not find the increase in factor VIII as did Egeberg and Owren.[5]

In 1965, in America, Donayre and Pincus[9] studied 64 women using norethynodrel 2.5 mg plus mestranol 0.1 mg (Enovid). They found no increase in factor VIII as had Owren and Egeberg. They did, however, find an increase in factor VII, factor VII-factor X complex, and a questionable increase in factor X alone. They also found an increase in prothrombin activity, fibrinogen levels, and an increase in fibrinolytic activity. However, they concluded that the significance of these alterations of clotting factors in relation to thromboembolic disease was not clear.

Again in England in 1966, Thomson and Poller,[10] studying 97 patients on a variety of oral contraceptives, reconfirmed their earlier finding of an associated increase in factor VII. They also noted an increase in factor X as previously described by Rutherford and his co-workers.

In summary, there are reports indicating the following changes in the clotting factors associated with oral contraceptives:

(1) Increase in factor VII;
(2) Increase in factor VIII;
(3) Increase in factor IX;
(4) Increase in factor X;
(5) Increase in prothrombin activity;
(6) Increase in serum fibrinogen levels; and
(7) Increase in fibrinolytic activity

The Influence of Pregnancy on Clotting Factors

In 1956, Alexander, et al[11] reported a comparative study of 41 normal, nonpregnant females, and 90 gravidas. They found a substantial increase in proconvertin activity, which is the relatively inactive precursor form of factor VII. This increase occurred predominantly during the last trimester. Moreover, the activity could be enhanced six to ninefold by incubation of plasma with thromboplastin and calcium. This suggests that the gravid woman is particularly susceptible to rapid prothrombin conversion if thromboplastic elements enter the circulation. These increased proconvertion levels dropped substantially by the third day postpartum, and levels were normal by six weeks postpartum. They also found a slight elevation of plasma prothrombin activity in the pregnant subjects. Plasma prothrombin activity remained elevated longer into the puerperium than did the proconvertin levels.

Gillman, et al[12] reported a study of 205 gravidas in whom they studied fibrinogen and fibrinolysin levels during pregnancy and immediately postpartum. The plasma fibrinogen levels showed significant and progressive increases above the control level obtained in early pregnancy until the 36th week, where they leveled off and remained quite high. The fibrinogen levels were followed for three weeks postpartum and showed no signs of decreasing during that period. They also measured fibrinolysin activity by measuring the euglobulinlysis time. It was apparent that the longer the euglobulinlysis time, the less the fibrinolysin activity. By the 13th to 28th week of pregnancy, there was a highly significant increase in the euglobulinlysis time. The euglobulinlysis time remained high until after the second stage of labor, but shortly after delivery, there was an abrupt decrease in its values with a simultaneous rise in fibrinolytic activity.

Pechet and Alexander[13] reported their observations in a group of 51 gravidas in whom there were significant elevations of values for factor VII, factor X, and factor VII complex, which is both VII and X combined. They did not find an increase in prothrombin activity. Ratnoff and Holland[14] found that there is an increase in plasma thromboplastin component (factor IX) in pregnancy.

The question might be asked: is estrogen or progesterone causing the clotting problems and does it take both acting together to cause thromboembolic problems? Daniel, et al,[15] in England, reported a review of 9,324 pregnancies in which there were 44 cases of phlebitis, pulmonary embolism, or deep vein thrombosis requiring the administration of anticoagulants. Postpartum, 6,227 (67 percent) of the patients who were not lactating were under treatment with diethylstilbesterol. The 44 cases of thromboembolic disease gave an incidence of 4.7/1000 deliveries. In lactating women, there were seven cases in 3,064 deliveries (2.3/1000 deliveries), whereas in nonlactating, estrogen-treated women, there were 37 cases in 6,227 deliveries (5.9/1000 deliveries). This suggests that estrogen alone can be related to an increased incidence of thromboembolism.

Oliver[16] described a five-year trial of ethinylestradiol treatment in men who had re-

covered from myocardial infarction. In the series there was a higher incidence of thrombophlebitis, pulmonory infarction, and cerebral vascular accidents in men treated with estrogen. This evidence also suggests that estrogen alone can be associated with an increase in thromboembolic disease.

Effects of Estrogen on Platelets

Caspary and Peberdy[17] tested the adhesiveness of platelets to a glass surface in the presence of an encephalitogenic factor, a low molecular weight histone derived from human brain. When the platelet adhesiveness of 12 women not taking birth control pills was compared to 12 men, the women showed greater adhesiveness. The stage of the menstual cycle had no demonstrable effect on the results. Twelve women taking norethynodrel 5 mg with ethinylestradiol 0.075 mg (Conovid) showed a greater platelet adhesiveness than the 12 women not using oral contraceptives.

Hampton and Mitchell[18] found that adenosine diphosphate (ADP) and norepinephrine cause a biphasic change in platelet electrophoretic mobility with low concentrations causing an increased mobility and high concentrations causing a decreased mobility. They also noted a maximum electrophoretic mobility of platelets which in normal subjects is attained by 0.05 μg per ml of ADP or norepinephrine, while 0.5 μg per ml of either agent resulted in decreased mobility. Bolton and co-workers[19] reported that patients taking oral contraceptives showed an increased platelet sensitivity to ADP but not to norepinephrine. This observation was similar to the report of Hampton and Mitchell[20] in which the electrophoretic behavior of platelets from patients with occlusive arterial disease was abnormal in that platelet sensitivity to ADP was increased while platelet sensitivity to norepinephrine was unaffected. Bolton and co-workers[19] further observed that two patients treated only with progesterone showed no increase in sensitivity to either compound. In patients taking natural estrogens there was no alteration of platelet electrophoretic sensitivity to ADP. This observation was similar to that of Elkeles and co-workers.[21] The authors concluded that similar changes in platelet mobility in patients on oral estrogen therapy and in occulsive arterial disease may indicate that the abnormal platelet behavior is related to thrombosis, and that indeed estrogen in the absence of progesterone is thrombogenic.

Margulis, et al[22] described an increase in platelet count over nonpregnant values during pregnancy and during treatment with oral contraceptives.

Effects of Estrogens on Veins

Goodrich, et al[23] reported a study of 20 gravidas in the third trimester contrasted to 20 nonpregnant women taking oral contraceptives. Using plethysmographic methods, they found an increase in venous distensibility or a loss of venous tone associated with pregnancy and with oral contraceptives. This change occurred both in the upper and lower extremities. These authors found an increase in blood flow in the upper extremities both during oral contraceptive therapy and during pregnancy, and both groups also had a decrease in the mean linear velocity of venous blood flow in the calf. These findings were supported in subsequent studies by Goodrich and Wood.[24]

Rosenberg,[25] at Touro Infirmary in New Orleans, reported two cases of pulmonary embolism in patients on oral contraceptives. He emphasized the previous observation that estrogens cause an elevation of plasma hydrocortisone and an increased plasma binding of the hormone. However, the overall effect is an increase in the mean level of unbound biologically active hydrocortisone as shown by Doe, et al.[26] Not only is the hydrocortisone level elevated in individuals given estrogen, but also there is a potentiation of the biologic effects of hydrocortisone when it is administered to estrogen-treated individuals as shown by Nelson, et al.[27] Rosenberg notes the earlier reports of Berntsen and Freyberg[28] and Kemper[29] in which use of hydrocortisone was associated with nonspecific vasculities. The author concludes that the ability of estrogens to raise plasma hydrocortisone levels could be related to an increased incidence of thromboembolic disease in patients taking estrogen preparations. The association of adrenal cortical hormone therapy and development of thrombophlebitis and pulmonary embolism has also been reported by Cosgriff[30] and Kern and associates.[31] Moore[32] discussed the elevation of adrenal cortical hormone levels after all types of surgery and the increased incidence of thromboembolic disease after surgery.

Other Cardiovascular Effects of Estrogens

Scherf[33] studied a group of menopausal females at the time of pronounced symptomatology in contrast to another group of patients with ovarian hypofunction. Electrocardiograph (EKG) findings in all subjects included: (1) sinus tachycardia, (2) prolongation of A-V conduction time, (3) depression of the S-T segment, and (4) flattening of the T-wave. Injection of estrogen resulted in the return of the EKG to normal.

In a more recent report, Grinnell and Smith[34] demonstrated that estrogens decreased the sensitivity of the dog myocardium to the toxic effects of digoxin. It was found that 0.15 mg digoxin per Kg body weight given intravenously caused, in 5 to 30 minutes, complete A-V dissociation and persistent idioventricular tachycardia. Estrogen prolong-

ed this time interval or prevented these changes completely. A similar study by Gimeno[35] reenforces the concept that estrogen can protect the myocardium from digitalis toxicity.

Ueland and Parer[36] reported on the effects of estrogen on sheep in which they found that intravenous infusion with Premarin resulted in an increased cardiac output, an increased heart rate, a decreased mean arterial pressure, and decreased peripheral resistance. This is not to imply that estrogen is a hypotensive agent, since, indeed, it has been associated with hypertension. Reports by the Food and Drug Administration[37] indicate that estrogens activate the renin-angiotensin mechanism.

King, et al[38] studied the effects of estrogen on the composition of cardiac muscle in rats and found that estrogen increases the actomyosin concentrations in the myocardium. Csapo[39] found that it does the same in the myometrium; however, Csapo found an increase in total uterine weight and total protein concentration with increase in estrogen level. King, in contrast, found that there is no change in total ventricular mass or in total protein concentration of ventricular muscle in relation to estrogen. King concluded that estrogen may act to influence the specific synthesis of contractile cardiac protein and that, in the absence of estrogen, actomyosin is replaced by some noncontractile cardiac protein without changes in total protein.

The Influence of Estrogens on Coronary Artery Disease

Stamler and others[40] studied 275 men under the age of 50 years, all of whom had had one or two myocardial infarctions. Some were given placebos and some were given estrogens in the form of Premarin for a period of six months. In the low risk patients, those with only one myocardial infarction, there was no difference in the mortality rate in the estrogen-treated group and the placebo group. In the high risk patients (those with two myocardial infarctions), the mortality rate was fourfold higher in the placebo group. This suggests that the Premarin had a beneficial effect.

In 1967, Oliver[16] reported the results of a five-year trial of ethinyl estradiol in men who had recovered from myocardial infarction. The trial, as was mentioned earlier, was designed to determine whether reduction of raised serum cholesterol level by an estrogen would improve prognosis after myocardial infarction. They treated 50 men with ethinyl estradiol, 100 μg, twice a day and even higher doses in some patients in order to get reductions of serum cholesterol. They found that ethinyl estradiol can reduce serum cholesterol to accepted values. However, the number of subsequent incidents of myocardial infarction or clinical ischemia did not differ significantly in the estrogen-treated and the control groups. They conclude that, in men with coronary heart disease, continued reduction of serum cholesterol does not reduce the incidence of subsequent infarction. However, there were more thromboembolic problems in the estrogen-treated group. They raise the point that any benefit from lowering the serum cholesterol might be annulled by an increased thrombotic tendency.

Marmorston et al[41] reported their study of 27,531 patients with known coronary artery disease who had recovered from a frank myocardial infarction. Groups of these patients were treated with ethinyl estradiol, conjugated estrogens, or placebo. Those treated with ethinyl estradiol had significantly lowered cholesterol-phospholipid ratios in contrast to those who received conjugated estrogens who had no such effect. They also found that conjugated estrogen therapy significantly improved survival, particularly in the first two years of treatment. The other estrogen preparations had no effect on survival as compared with placebo treatment. They found that the patients most likely to benefit from conjugated estrogen therapy were those with relatively poor initial prognosis, that is, men under 55 years, who had had a first myocardial infarction and those with clinical evidence of arteriosclerotic heart disease. They concluded that altering the serum cholesterol does not necessarily improve survival, and survival may be improved without altering the serum lipids.

Another very interesting type of vascular accident has been associated with oral contraceptives. In 1968, Brennan and others,[42] in New Zealand, reported two cases of midgut infarction in women taking oral contraceptives. In both cases there was no significant amount of atheroma, but both patients had large thrombi in their superior mesenteric arteries. Both patients had frank gangrene from mid-duodenum to the midtransverse colon. Patient No. 1 was 38 years old, was not resected, and died. Patient No. 2 was resected and lived with obvious nutritional problems. These workers recommend that immediate discontinuation of oral contraceptives be considered in women in whom acute abdominal pain develops. They suggest that unexplained abdominal pain in women on oral contraceptives during the latter half of their reproductive life is sufficient ground for cessation of therapy.

Kilpatrick, et al[43] reported two cases of women on oral contraceptives who also presented with abdominal pain and bloody diarrhea. X-rays showed narrowing of the large bowel lumen and intramural thumbprint filling defects, findings characteristic of vascular injury of the colon. In both cases an area of large bowel from the

hepatic flexure to the cecum was involved. Both of these patients had clinical and x-ray reversal of their x-ray findings after the cessation of oral contraceptives.

Summary

1. Reports indicate that estrogen therapy is associated with the following changes in the clotting factors:

(1) Increase in factor VII;
(2) Increase in factor VIII;
(3) Increase in factor IX:
(4) Increase in factor X;
(5) Increase in prothrombin activity;
(6) Increase in serum fibrinogen levels; and
(7) Increase in fibrinolytic activity.

2. Reports indicate that pregnancy is associated with the following changes:

(1) Increase in proconvertin activity;
(2) Increase in prothrombin activity;
(3) Increase in fibrinogen levels;
(4) Decrease in fibrinolytic activity;
(5) Increase in factor X; and
(6) Increase in factor IX

3. Estrogen alone appears to be related to an increased incidence of thromboembolism.

4. Abnormal electrophoretic platelet behavior associated with estrogen therapy may be related to thrombosis.

5. Estrogens appear to cause an increase in venous distensibility with a decrease in the mean linear velocity of venous blood flow in the calf.

6. The action of estrogens to increase plasma corticol levels may cause thrombosis, since hypercorticalism is thought to be a thrombogenic condition.

7. Estrogens protect the dog myocardium from the toxic effects of digitalis.

8. Estrogen is associated with an increased cardiac output, an increased heart rate, a decreased mean arterial pressure, and decreased peripheral resistance in sheep.

9. Estrogen increases the actomyosin concentrations in the myocardium.

10. Conjugated estrogens seem to have a beneficial effect in decreasing mortality in patients who have had myocardial infarctions, especially in high risk patients.

11. Bowel infarction has been reported in females taking estrogen compounds.

Generic and Trade Names of Drugs

Norethynodrel with mestranol — Enovid (Searle & Co.)
Norethynodrel with ethinylestradiol — Conovid (Searle & Co.)
Conjugated estrogens (equine) — Premarin (Ayerst Laboratories)

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Self-Evaluation Quiz

1. In selecting a deep heating modality for use over an artificial hip joint, in order to avoid tissue damage one should order:
   (A) Short wave diathermy
   (B) Microwave diathermy
   (C) Ultrasonic diathermy
   (D) Infrared radiation
   (E) None of the above

[*From the Department of Physical Medicine, The Ohio State University College of Medicine. The answer is given on p. 1026 of this issue.—Ed.*]

2. In the management of degenerative disk disease of the cervical spine, traction is often of help. The magnitude of the weight applied as intermittent traction should reach:
   (A) 50 to 60 lb.
   (B) 25 to 30 lb.
   (C) Hardly ever more than 10 lb.
   (D) 100 lb.
   (E) None of the above

[*From the Department of Physical Medicine, The Ohio State University College of Medicine. The answer is given on p. 1026 of this issue.—Ed.*]

Must Parietal Peritoneum Be Sutured After Abdominal Surgery?

Technic of Not Suturing Used on 150 Patients

Emmet T. Sheeran, M.D.

AFTER MAJOR ABDOMINAL SURGERY, it has been customary in wound closure for the surgeon to suture the parietal peritoneum. This report concerns a departure from the usual closure technic in that the parietal peritoneum was *not* sutured.

In 1962, Harkins and Nyhus[1] suggested that the ligamentum teres of the liver and the falciform ligament adhere and form a more natural anatomic closure than is achieved by sutures. Hubbard and associates,[2] in 1967, stated: "It has been shown that peritoneum regenerates *de novo* and not from the cut edges of a defect and that an open defect results in fewer adhesions than a closed one." With these principles in mind, in July 1967, I performed a partial gastrectomy through an epigastric midline incision, and deliberately left the parietal peritoneum open—unsutured. The patient had an uneventual recovery. Since then I have left the peritoneum open in 164 operations on 149 patients.

Technic

In midline incisions, I closed the linea alba with simple interrupted sutures of 28-gauge monofilament stainless steel wire or 00 silk (Figs. 1, 2, and 3). In the lower half or two-thirds of upper paramedian incisions, it was necessary to include peritoneum in the mass sutures where peritoneum was fused with the posterior rectus sheath (Fig. 4). No cases closed by this technic were included in the present series. McBurney's incisions were closed with interrupted sutures of 00 chromic gut in the muscle and aponeurotic layers. Peritoneum and fascia transversalis were not sutured.

In inguinal and femoral herniorrhaphies, I excised the sac, ligated any vessels that were present, and allowed the cut edges to retract within the abdominal cavity. No attempt was made to suture or ligate the neck of the sac. It remained open. Then followed the usual repair, whether it was only narrowing the internal ring about the cord, or, additionally, bringing a curtain of fascia down to Poupart's ligament or Cooper's ligament.

Clinical Data and Results

Of the 150 patients in the series, there were 65 males and 85 females, ranging in age from 9 months to 88 years, with a median age of 46 years. The 165 operations on the 150 patients involved the following approaches: lower midline incision (57), oblique inguinal incision for herniorrhaphy (49), complete xiphoid-to-pubis incision (14), three-quarter complete midline incision (11), upper midline incision (22), McBurney's

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• **Dr. Sheeran, Fostoria, is a member of the Surgical Staff at Fostoria City Hospital.**

Submitted February 16, 1970.

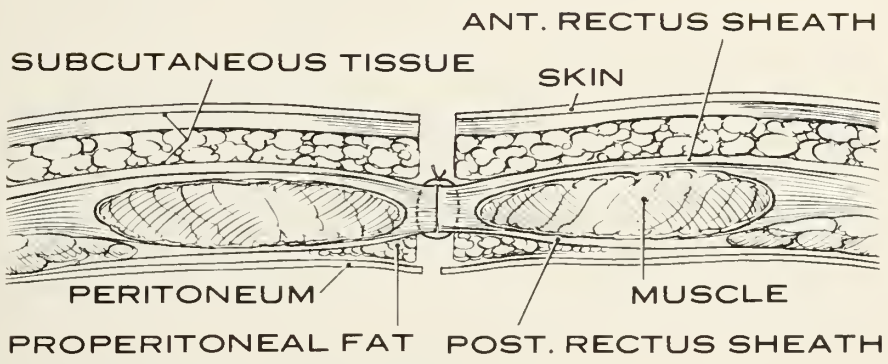


Fig. 1. Suture of linea alba in epigastrium.

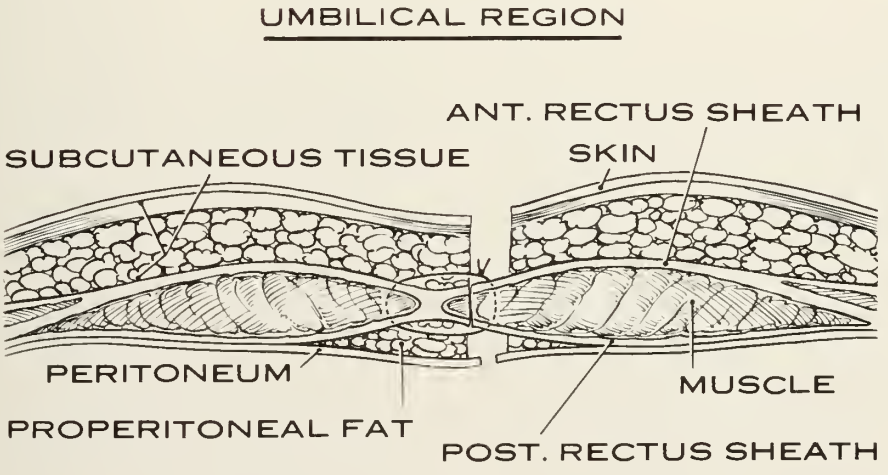


Fig. 2. Suture of linea alba in umbilical region.

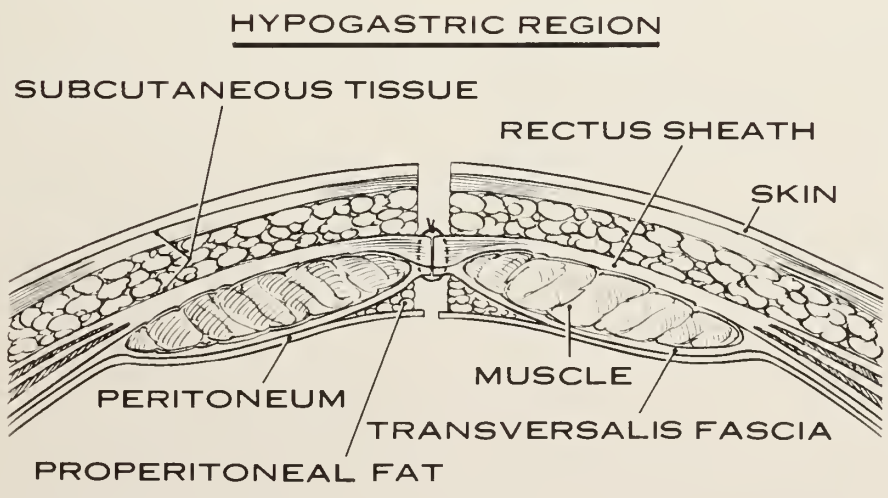


Fig. 3. Suture of linea alba in hypogastric region.

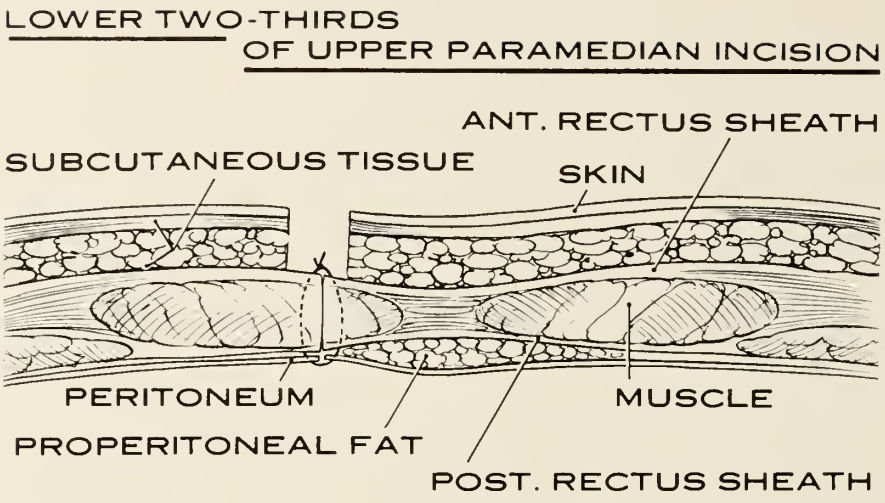


Fig. 4. Suture of upper paramedian incision.

incision (8), transverse incision (2), right rectus incision (1), and left rectus incision (1).

In the rather short period of follow-up study, 146 patients have had satisfactory results. Three patients died, but death was not attributable to the fact that the peritoneum had not been sutured. The first death was caused by severe respiratory acidosis with cardiac arrest during drainage of a pelvic abscess. The second death occurred in a nearly moribund patient who had gastrostomy and jejunostomy for an obstructing marginal ulcer. The most recent fatality was caused by massive pulmonary embolism five days after combined abdominal-perineal resection of the rectum.

One patient, a 58-year-old man, who had undergone anterior resection of a rectosigmoid carcinoma and whose fascia was of poor quality, had an evisceration that occurred through the central portion of a long midline incision from the pubis up into the epigastrium. The evisceration was closed with simple through-and-through sutures of 28-gauge stainless steel wire in fascia and muscle. The peritoneum again was left open. The incision healed uneventfully, and there is no sign of hernia.

Several patients underwent re-operation for various reasons: gastric resection, repeat cesarean section, complete hysterectomy, colon resection. In each instance the undersurface of the previous incision was found to be smooth and free of adhesions.

There have been no recurrences of inguinal or femoral hernia, but the longest period of follow-up is not quite 2½ years.

Summary and Conclusion

The conventional suturing of parietal peritoneum was not performed in 165 operations on 150 patients after major abdominal surgery; *the parietal peritoneum was not sutured but was left open.* Three patients died of causes not related to the technic of not suturing the parietal peritoneum. One patient had an evisceration but recovered uneventfully after repair. My experience leads me to believe that it is not necessary to suture the parietal peritoneum after major abdominal surgery.

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Aspirin and Arthritis

Marvin H. Thomas, M.D.

IF A BASIC "DIET" underlies the modern treatment of diabetes, so is aspirin the foundation of the proper treatment of arthritis. Aspirin is the "building-block," whatever additional treatment may be added. Perhaps its easy availability without prescription causes many patients (and unfortunately many physicians) to look upon aspirin as a "non-drug."

Aspirin was introduced in 1896 for the treatment of rheumatic diseases. It remains today the first and most widely used medication for arthritis. Its value in rheumatoid arthritis derives not only from its analgesic effect but, more importantly, from its *anti*-inflammatory effects. Studies have recently shown aspirin to have an effect on immunologic processes — a potentially important consideration in view of ever-increasing evidence that rheumatoid arthritis may be an auto-immune disease.

To achieve an anti-inflammatory effect, one should attempt to use maximally tolerated doses. This amount differs from patient to patient and must be individualized, since factors such as age (younger patients tolerate higher doses without salicylism), weight, renal function (clearance of salicylate is increased in alkaline pH), and level of serum albumin affect the required daily dose. Though a calculated dosage to obtain plasma salicylate of 20 mg. per 100 ml. is desirable, in common practice one can arrive at this dosage without resorting to blood measurements. The first symptom of over-dosage toxicity in the adult is tinnitus and usually some degree of deafness. These symptoms can be used as end points. Most patients can initiate therapy with at least 10 to 12 five-grain tablets daily. This dose can gradually be increased until tinnitus occurs. At that point, the daily dosage can be decreased by one or two tablets, or whatever is needed to eliminate the tinnitus. The maximal sub-tinnitus dosage is that patient's maintenance dosage, to be taken in addition to any other antirheumatic agent. It is important to remember that salicylate ototoxicity, even of long duration, is completely reversible and leaves no permanent effects.[1]

While there is no doubt as to the efficacy of salicylates in rheumatoid arthritis, patient acceptance may be a problem. Aside from the need simply to swallow a number of tablets daily, adverse effects do occur.

Subjective and objective changes in the gastrointestinal tract are the major problems. Dyspepsia, presenting as heartburn, epigastric distress, nausea, and vomiting, may follow aspirin ingestion. Muir[2] reported these symptoms in 5 per cent of 3,000 patients. Dyspepsia, common in the first few days of high dose therapy, often disappears as treatment continues.

Aspirin is an ulcerogenic agent. Dyspepsia and ulcer can be avoided by taking aspirin with food, the concomitant use of antacids, or use of buffered and enteric-coated preparations. All should be tried, although absorption of enteric-coated aspirin for several reasons is unpredictable or unreliable. Further, uncoated tablets which dissolve very slowly are more troublesome than rapidly dispersing tablets and should be avoided, as local irritative effects probably account for greater frequency of dyspepsia as well as upper

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The Arthritis Page is a quarterly feature of *The Journal* supplied by the Ohio Rheumatism Society.

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Submitted March 2, 1970.

GI bleeding. Gastrointestinal effects are not entirely due to local irritation of the stomach, since Caravati and Cosgrove[3] found intravenous doses to produce similar symptoms. It should be remembered, however, that some patients who profess invariable dyspepsia from aspirin can tolerate various preparations containing salicylates on a "double-blind" basis.

Occult GI bleeding has been reported in 40 to 70 percent of patients ingesting aspirin daily. Ordinarily, losses average only from 2 to 6 ml. per day, but they can be larger and sometimes result in iron-deficiency anemia. It has been repeatedly shown that there is no relation between dyspeptic symptoms and the subsequent development of occult or massive bleeding. Grossman[4] has shown that subjects who bled following oral aspirin also bled after intravenous acetylsalicylic acid. While various theories have been advanced to explain the mechanism of bleeding (including decreased gastric mucous production, increased gastric mucosal blood flow, shedding of mucosal cells, and interference with clotting factors), none has met universal acceptance. Severe gastric hemorrhage is uncommon but can be a major emergency. Patients with an underlying lesion, particularly peptic ulcer disease, are more prone to this complication.

Aside from the common GI side effects, idiosyncratic reactions are a rare but dramatic risk. Aspirin allergy, though more frequent in those with a known asthmatic or allergic history, and particularly in those with nasal polyps, has an estimated incidence of about two per thousand. Skin lesions may also be encountered and are usually pruritic. Aspirin may exacerbate chronic urticaria and should not be used in a patient with a history of this condition. Despite these effects, no patient with active arthritis should be denied the benefits of aspirin used with conviction and intelligence.

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Answers to Self-Evaluation Quiz

Page 1021 Question 1. (C) The only deep heating modality which is safe to use over a metallic implant is ultra sound.

Page 1021 Question 2. (A) The weight of the head is about 9 lb. in an adult, and with 25 lb. of traction, the cervical spine straightens, but it requires more than 45 lb. to cause distraction at the intervertebral cervical disk interspaces. Intermittent traction should be used at 50 to 60 lb. in the usual individual.

The Outlook for Patients with Severe Acquired Valvular Aortic Stenosis

John Ross, Jr., M.D.*

ACCURATE INFORMATION concerning the true natural history of patients with severe acquired valvular aortic stenosis has been difficult to obtain. This is the case not only because operation frequently has interrupted the natural course in recent years, but also because the advent of means for the accurate assessment of the severity of stenosis by left heart catheterization is a relatively recent development. Before recommending operation in adult patients with valvular aortic stenosis, it is clearly of great importance to understand the natural history of this disease, so that the outlook in patients medically managed may be compared with that offered by surgical treatment. Adding to the importance of such a consideration are the particular problems of sudden death in patients with this disease and the continued relatively high mortality and morbidity rates associated with aortic valve replacement.

The advanced age at death of patients with severe acquired aortic stenosis has been a consistent feature in postmortem studies of patients with this disease. About three quarters of such patients are males, and the average duration of their symptoms is short, a history of angina pectoris having been present for an average of three years, syncope for three years, and congestive heart failure for 1.5 to 2 years (Table 1).[1-5]

This pattern, a long latent period, followed by onset of symptoms during the fifth or six decades of life, presumably reflects progressive aortic stenosis due to thickening and calcification of a congenitally or rheumatically deformed valve, progressive myocardial dysfunction related to the long-standing mechanical overload, or both. Once significant symptoms of angina, syncope, or heart failure develop, the average course is short, culminating in death at an average age of 63 years.[5]

The problem of sudden death deserves special consideration relative to the outlook of patients with aortic stenosis. Among patients dying with acquired valvular aortic stenosis, death was sudden in 15 to 20 percent and occurred at an average age of 60 years.[1,4,6,7] Sudden death tended to occur in patients with symptoms, and 65 to 80 percent of patients coming to autopsy after sudden death had a history of angina pectoris, heart failure, or syncope.[1,6,7] Thus, it should be emphasized that only 3 to 5 percent of the deaths in patients with acquired aortic stenosis occur suddenly in patients who have no significant symptoms. In connection with angina pectoris, it should be noted that 12 to 20 percent of patients with aortic stenosis who suddenly die have evidence at postmortem examination of old or recent myocardial infarction.

When data are summarized from clinical rather than postmortem studies, the patients have been encountered somewhat earlier in their course, their average age being 48 years. In the clinical reviews published prior to 1955, that is prior to the hemodynamic and the surgical era, symptoms were present in the great majority of patients (Table 1). The most common complaint was angina pectoris, the average duration of which was five years, and in only 5 percent of patients was angina pectoris of long duration (10 to 20 years). The average incidence of syncope was 15 percent. Although the histories of syncope averaged three to four years, the range was generally wide, and this symptom was present in some patients for as

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Provided by the American Heart Association, Inc. and made available to *The Journal* by the Ohio State Heart Association.

long as 18 years. A prolonged history of symptoms related to left heart failure was unusual, its duration averaging only two years at the time the paients came under observation.[1]

The few available prospective studies tend to confirm these relatively short clinical histories (Table 1). Grant, in 1933, reported that 65 percent of symptomatic patients with aortic stenosis, some of whom had associated aortic regurgitation, were dead at the end of ten years.[10] More recently, in 1958, Wood[11] described 64 patients, who were considered clinically to have severe aortic stenosis but who were not subjected to operation and who were followed for periods of one to seven years. Half were lost to follow-up, but 56 percent of the remaining 32 patients died during the period of observation. Takeda and co-workers followed 60 patients after their admission to the hospital with a diagnosis of isolated aortic valve stenosis; 82 percent were dead after 4 to 15 years.[12]

Before turning to a consideration of results of cardiac surgery in patients with aortic stenosis, it is worthwhile to consider further the outlook for patients with severe aortic stenosis in whom the lesion has been documented objectively by hemodynamic means. Recently, a study was undertaken at the National Heart Institute to gain follow-up information on patients studied by left heart catheterization prior to the advent of the ball-valve prosthesis, in whom the clinical course was not interrupted by operation. During the past 14 years, a group of 15 such patients with severe valvular aortic stenosis were studied in whom a long follow-up could be obtained.[13] Some patients refused operation, others were considered too ill at that time for operation, and, in some, symptoms were not sufficiently severe to warrant operation. When these patients were first seen their ages ranged from 32 to 59 years; there were 12 men and three women. All had significant aortic stenosis, with a pressure gradient between left ventricle and brachial artery of more than 50 mm Hg, a valve orifice area index $\leqq 0.70$ cm^2/M^2 body surface area (BSA), or both. No associated mitral valve disease was detected nor was there significant aortic regurgitation in any patient. The 15 patients were followed for periods up to 12 years after initial hemodynamic study. The average age at onset of symptoms was 48 years, and the average life expectancy after the onset of symptoms was less than four years. Ten of the 15 patients were dead at the end of the follow-up period. There were no hemodynamic differences between the patients who survived and those who died, and there were no important differences in the incidence of symptoms in the survivors and nonsurvivors. At the end of 4½ years, 50 percent of the patients were dead, and at the end of eight years, 80 percent of those followed were dead. It also

Table 1. Acquired Valvular Aortic Stenosis Course Without Surgery

	Av. Age Yrs.	Av. Duration History, Years: Angina	Syncope	CHF	Clinical Follow-up	Duration Yrs.	% Known Dead
(Death)							
Postmortem Studies (1933-1961)	63 (males)	3	3	1½ 2			
(First seen)							
Clinical Studies (Pts. with Symptoms, 1934-1966)	48	5	1-18	2	Grant 1933	10	65
					Wood 1958	1-7	50

is of interest that the clinical course after the onset of angina pectoris, syncope, or heart failure in each of the patients who died was not influenced by the age at which the symptoms began, being rapid at any age.

Given these general facts concerning the prognosis of patients with acquired aortic stenosis treated medically, it is possible to consider the results of more recently developed surgical methods and to develop a reasoned approach concerning recommendation of operation in patients with this disease.

The initial results with surgical replacement of the aortic valve with a ball-valve prosthesis or aortic valve homograft in several large centers are summarized in Table 2.[14-18] In patients preoperatively in Classes II to IV of the New York Heart Association classification who have been followed postoperatively for periods of eight months to four years, the hospital mortality rate has averaged 23 percent. In the surviving group, the results have been listed as poor in an average of 12 percent of patients, peripheral emboli having occurred in 9 to 15 percent of patients. In more than 80 percent of the survivors, however, the clinical result has been described as good or excellent. A representative operative series (from the National Heart Institute) of patients with isolated aortic valve disease (aortic stenosis and/or regurgitation) in whom a Starr-Edwards prosthesis was inserted may

Table 2. Acquired Valvular Aortic Stenosis Operative Results (Valve Replacement)

Followup	Av. Mortality % Early	Late	Total		Av. Results, Survivors*
1-5 yrs.	4-20	4-14	16-30 Av.-23%	85% Good	15% Poor (emboli, AI, symptoms)

*NIH 1966

be considered in somewhat more detail. This series included 133 patients operated upon and followed during a four-year period (1963-1967).[19] The operative mortality rate was 16 percent, and the late mortality rate 15 percent. All of the surviving patients were improved. Prior to operation, approximately one quarter of the patients were in functional Class II, while the remaining three quarters were in Class III or IV. Postoperatively, more than three quarters of the patients were in functional Class I and of the 112 patients who survived, almost all have so far gained approximately two years of Class I or II existence.[19] Hemodynamic studies tended to corroborate the clinical improvement, the average gradient preoperatively from left ventricle to aorta being approximately 95 mm Hg in patients with aortic stenosis and postoperatively less than 20 mm Hg. The late mortality rate (15 percent) following discharge from the hospital included sudden death in eight patients, coronary artery emboli in two patients, bacterial endocarditis in one patient, ball variance in three patients, and several other miscellaneous causes. An initial important cause of morbidity and mortality, thromboembolism, has been reduced by anticoagulation as well as by the recent development of a fabric covered prosthesis that allows ingrowth of autologous tissue.[20] As in the patient not operated upon, however, the problem of sudden death remains a serious cause of mortality in patients with aortic prostheses.

It may be concluded from the above analysis of natural history and the results of surgical treatment in patients with acquired aortic stenosis that when significant symptoms develop the immediate outlook is poor, but it can be improved substantially by replacement of the aortic valve with a prosthesis. Thus, the risk of operation itself and the late postoperative mortality combined (about 20 percent) are lower over the four-to-five year period in such patients than the risk of nonoperative treatment (about 50 percent). In addition, the symptomatic improvement in most of the survivors of operation has been considerable, many having been offered several years of relatively normal existence. Although it is clear that when the degree of stenosis as documented by left heart catheterization is not severe, operation should not be recommended, the problem of whether or not to recommend operation in patients with severe stenosis who have few or no symptoms remains unsettled. Since it is unknown whether or not the mortality and complication rates observed during the first few years after valve replacement will continue at their current trend and since prospective studies are not yet available on the prognosis for patients with severe stenosis but few or no symptoms, it seems wisest, for the present, not to recommend operation in such patients. Detailed analysis of long-term studies concerning operative results are now in progress, and it may be hoped that these and other prospective studies will clarify these issues.

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Professional Activities

General Practitioner of the Year

Thomas E. Rardin, M.D. Receives First Award
Future Awards Will Be Presented in His Honor

THE FIRST General Practitioner of the Year Award was presented to Thomas E. Rardin, M.D., Columbus, on August 4 at the annual assembly of the Ohio Academy of General Practice in Columbus. In the words of Lauren M. Brown, M.D., Academy vice-president, "So that Dr. Rardin's thoughts, ideals and beliefs will always be foremost in our minds we have named this the Thomas E. Rardin Award and it will be presented annually."

Following is a personal tribute to Dr. Rardin prepared and presented by A. R. Marsicano, M.D., also of Columbus.

* * *

I thank you for this opportunity to talk to you about a friend of mine — a very close friend and colleague for almost thirty years. I can't say much that is not already very well known to everyone of you here tonight. As a matter of fact, this man's accomplishments are known to members of our profession throughout the nation. I feel like I am reviewing a powerful movie to a room full of people who have just seen the show. The fact that the principal player is seated in the audience makes my task even more exacting and exciting.

I first met Tom Rardin during the early stages of World War II at a leveled off swamp in middle Georgia where, in characteristic Rardin style, he was engaged in organizing from scratch the United States Air Force Field Service School, an original institution that was to turn out thousands of trained medical teams that served throughout the Pacific Theater of War. For this colossal achievement he was awarded a Presidential Citation and the Legion of Merit.

These might have been the first awards Tom had received in his young life but the masterpiece of organizational accomplishment that won these commendations was not his first effort. In the late thirties Tom Rardin had helped organize and put into practical operation what probably was the first Menopausal Clinic in the United States — the forerunner of today's Endocrinology Clinic.

After discharge from military duty, Tom was ready to put these military training principles to civilian use. He was instrumental in establishing a Department of Audiovisual Education at Ohio State University College of Medicine where he held the rank of assistant professor. These concepts of multiple sensory bombardment through audiovisual stimulation showed Tom's early flair for progress in the teaching of the young medical student. This pursuit of new methods and ideas underlines his personal philosophy of medical practice and was the driving force in what he envisioned for the future of General Practice. In today's vernacular Tom Rardin was and is a NOW guy!

In Tom's mind organization is everything. Thus, his first step was to help establish a strong G.P. organization. The fact that we are here tonight is evidence of the success of our Founding

Fathers. Tom was a charter member of the Ohio Academy and the American Academy of General Practice, serving as president of the Ohio organization. How he made those early scientific meetings hum with enthusiasm and originality!

There then followed 22 years of active, dedicated service to all of Organized Medicine. He has served on the Committee on Education of OSMA and the Committee of General Practice of the American Medical Association, which he later served as chairman.

But Tom happens to be more than a committee man. He is by nature a doer. He kept up his lecturing at Ohio State and travelled all over the country lecturing on a subject that has made him an international authority: Medical Education and the Training of the Modern Family Doctor. His articles on this subject have been published repeatedly in medical journals everywhere. As a matter of fact, he is probably the only General Practitioner to have five articles published in the *Journal of the American Medical Association,* a prestige periodical with a tough reputation for being highly selective in accepting manuscripts for publication. Just a few days ago I learned through the grapevine that an unprecedented sixth paper has been accepted and will appear in *JAMA* toward the year's end.

This history-making, ground-breaking article deals with a brilliant piece of office research that proves that Family Practice can offer real potential and may stimulate some of us to organize our thoughts and contribute to the medical literature. At present I understand he is putting together a Scientific Exhibit for the 1971 meeting of the American Medical Association.

His lectures, publications and ability to generate an air of electrical urgency through his unbounding enthusiasm provided the impetus that saw the creation of the new American Board of Family Practice.

And this is perhaps a good time to point out the obvious — that a tremendous amount of this spectacular achievement has occurred after Tom underwent a heroic piece of violent major surgery in 1955. The true measure of this unbelieveable man is that within six months, equipped with crutches, a gadget-laden, specially rigged automobile, and a smaller, lighter medical bag, he was back ministering to and serving his community by day and night. He has become a familiar silhouette on the streets of Upper Arlington and the halls of the City's hospitals.

Needless to say, many honors have come his way. He is the only Academy member to my knowledge who is an associate member of the Royal College of General Practitioners of Great Britain. American Medical organizations have already bestowed many prestigious honors upon him and are still doing so. This alert accomplishment led Dr. Robert Zollinger to succinctly remark that "Once in a while Organized Medicine does the proper thing at the proper time."

Tom Rardin's name appeared in *Who's Who in the Midwest* and is listed in *Who's Important in American Medicine.*

He has been appointed to the Honorary Council of Nu Sigma Nu.

Lay organizations have also paid tribute to his contributions as a doctor and citizen. Tom is especially proud of his Certificate of Merit from the Metropolitan Health Council and the Council of Social Agencies which he served as member for many years and as chairman in 1949, 1950, and 1951.

Kiwanis of Columbus has awarded him their Distinguished Service Citation.

In May 1969 he received the Distinguished Service Citation of the Ohio State Medical Association and on April 18, 1970 the Ohio State University College of Medicine presented him the Alumni Achievement Award.

And here he is again tonight to share in another high honor with other distinguished and highly qualified Ohio physicians. It is my belief that few men have served Medicine, as my friend, Thomas Edward Rardin has. As a physician, citizen, teacher, humanitarian he epitomizes the Classic Concept of Family Doctor. He has faced personal health catastrophes with the same courage, insight, and wisdom that he has instilled in his students and patients. His achievements make fiction pale in comparison. One has to stand in awe of a man capable of such vision, dedication and altruism.

Ophthalmology Course Offered by Kentucky U

On December 18 and 19 "Practical Ophthalmology for the Primary Physician" will be given at the University of Kentucky Medical Center. This two day course for generalists in medicine, pediatrics and family medicine will review common problems in ophthalmologic diagnosis and management. Practical methods will be stressed. Criteria will be given for identifying patients requiring specialized care. For further information regarding this program, contact Frank R. Lemon, M.D., Associate Dean, Continuing Education, College of Medicine, University of Kentucky, Lexington, Kentucky 40506.

Ohio TB Hospitals Designated; Per Diem Rate Announced

Following is the text of two communications forwarded by Emmett W. Arnold, M.D., director of the Ohio Department of Health, to health commissioners and boards of county commissioners throughout the state, regarding designation of tuberculosis hospitals and the per diem rate for tuberculosis service.

* * *

Subject: Annual Designation of Tuberculosis Hospitals

Pursuant to Section 339.20 of the Ohio Revised Code, the following tuberculosis hospitals have been designated in addition to the state tuberculosis hospitals as those needed to provide sufficient beds for all residents of the State of Ohio requiring maintenance, care, and treatment for tuberculosis on and after October 1, 1970:

Benjamin Franklin Hospital, Columbus

Dunham Hospital of Hamilton County, Cincinnati

Lowman Pavilion, Cleveland Metropolitan General Hospital, Cleveland

Ottawa Valley Hospital, Lima

Sunny Acres, Cuyahoga County Tuberculosis Hospital, Cleveland

William Roche Memorial Hospital, Toledo

You are further advised that effective October 1, 1970, as provided in Section 339.43 of the Ohio Revised Code, the State of Ohio will pay to the board of trustees, or to the board of county commissioners serving as a board of trustees, of any county, district, or other tuberculosis hospital, designated by the Director of Health, as provided in Section 339.20 of the Revised Code, the sum of five dollars per day for each patient hospitalized for the treatment of tuberculosis in such hospital by any county, and for those whose care and treatment the county was legally obligated to pay, to be credited to the county in which the patient has legal residence as part payment of the per diem charge for the hospitalization of such patient.

The board of trustees of each such county, district, or other hospital shall, not later than the fifteenth day of each month, certify to the Auditor of State, on forms provided by the Auditor of State, the number of persons hospitalized during the preceding month for the care and treatment of tuberculosis, the number of days each such person was a patient, the name of such patient, and the county of his legal residence. Upon receipt of such certification, the Auditor of State shall draw warrants in the amount found to be due, on the Treasurer of State, payable out of the general revenue fund, in favor of the trustees of such county, municipal, or district tuberculosis hospital.

State subsidy will not be paid to tuberculosis hospitals that have not been designated under the provisions of Section 339.20 of the Ohio Revised Code.

* * *

Subject: Per diem rate at the Tuberculosis Service at the Ohio State University and Southeast Ohio Tuberculosis Hospital

This is to advise you that the per diem rate to be charged for care and treatment of patients admitted to the tuberculosis service at the Ohio State University and the Southeast Ohio Tuberculosis Hospital will be thirty-five dollars ($35.00) effective October 1, 1970. This rate has been established pursuant to sections 3335.44 and 3701.83 of the Revised Code.

Dayton Children's Center Schedules Birth Defects Seminar

The Children's Medical Center, Dayton, has arranged a one-day seminar, "The Prevention of Birth Defects and Mental Retardation," to be presented from 10 a.m. to 5 p.m. on Wednesday, November 4 at the Imperial House North Motel, Dayton. Dr. Meinhard Robinow, director of the Birth Defects Clinic at the center, has arranged the program.

The seminar is open to all general practitioners, obstetricians, anesthesiologists and pediatricians.

Speakers for the seminar will be: Thomas K. Oliver, Jr., M.D., chairman, Department of Pediatrics. The Children's Hospital, Pittsburgh, Pennsylvania; Richard L. Naeye, M.D., professor and chairman, Department of Pathology, Milton S. Hershey Medical Center, Pennsylvania State University, Hershey, Pa.; Edward T. Bowe, M.D., professor, Department of Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York N. Y.; and William G. Thurman, M.D., professor and chairman, Department of Pediatrics, University of Virginia School of Medicine, Charlottesville, Va.

Contact the Children's Medical Center, 1735 Chapel Street, Dayton 45404.



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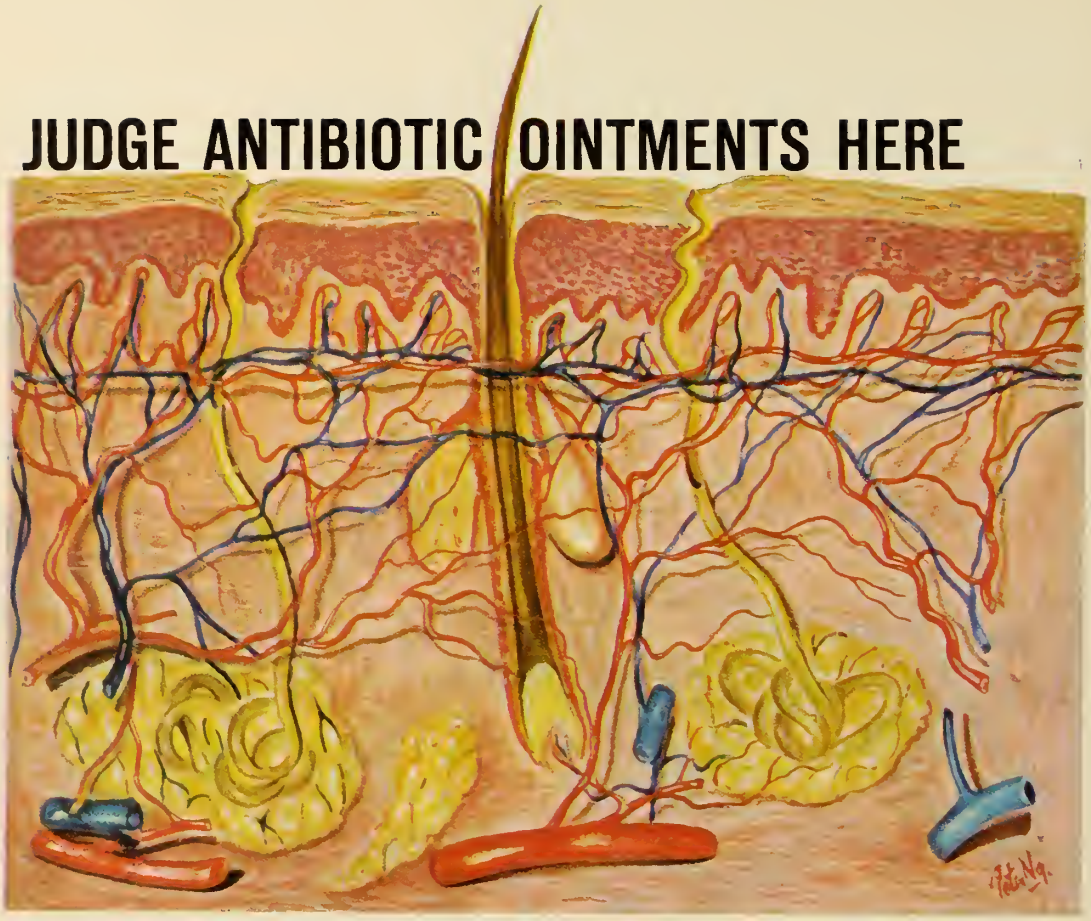
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Highlights in Ohio Welfare

Functions and Structure of the Division of Medical Assistance

THE WELFARE COLUMN in last month's issue of *The Journal* outlined the organization of the Ohio Department of Public Welfare in order to place the Division of Medical Assistance in proper perspective. This month we'd like to present a breakdown of the Division of Medical Assistance so that our readers will have a better understanding of its function and structure.

The Division of Medical Assistance is multi-purpose in nature. It develops policies and procedures for providing health care for all recipients who receive public assistance. This material is provided for use by county welfare departments. It advises District Deputy Directors on policy interpretation, gives technical supervision to district health care consultants, and gives authorization for health services requiring prior approval. It determines eligibility for applicants for public assistance when required, and it maintains the civil rights program records of all applicants and recipients in hospitals and nursing home facilities.

To fulfill all of its responsibilities, the Division is broken down into units, each contributing its share to the overall function. It should be noted that each unit is staffed with adequate professional personnel.

First, the Medical Consultation Unit has responsibility in three areas: it issues all necessary prior authorizations for medical services; it provides consultation to nursing homes and county welfare departments; and, where indicated it reviews billings submitted by providers of medical services.

The Consultation Unit's workload is not small. For example, the Unit has processed 10,126 prior authorization determinations during the first eight months of this year. To insure proper professional evaluation of any case it processes, the Unit is composed of a Supervisor, four nurses, a pharmacist, three reviewers and a six-person clerical staff. In addition, the Unit has the advantage of more than 300 hours of part-time consultation furnished monthly by eight physicians representing six different fields of medicine, a dentist, a podiatrist, an optometrist, and an audiologist.

The Disability Determination Unit, by use of medical-social review teams made up of a physician and a social worker, determines the extent of disability of applicants for Aid to Dependent Children — Incapacitated Fathers and for Aid for Disabled. During the first six months of 1970 the Unit considered 12,463 applications for initial or continuing aid grants. As in the case of the Medical Consultation Unit, the DD Unit staff is made up of highly-trained, professional people — a supervisor, full-time physician, two part-time physicians, a medical social worker, and a four-person clerical staff.

The Psychiatric Unit, supervised by a psychiatric social worker, is responsible for coordinating the medical assistance program for aged individuals in state mental institutions. Approximately 3,500 patient-recipients are covered by the program.

A constant monitor of programs of the Division of Medical Assistance is provided by the Utilization Review Unit. The Division's activities are under constant scrutiny to make sure that all objectives of the Division are adequately implemented. The Review Unit is a full-time effort by a dentist, a drug marketing expert, a trained hospital administrator, and a specialist in electronic data processing programs.

Ten Medical Assistance consultants are assigned to the various departmental district offices throughout the state. This staff, consisting of registered nurses and former rehabilitation counselors, provides consultation to practitioners, county welfare departments, and various health facilities regarding program operation and procedures.

The units whose responsibilities we have outlined are welded into an effective administrative organization by direction from a Division Chief and an Assistance Division Chief, both of whom have available the advice of a full-time medical consultant. All of the units within the Division are staffed with the intention to provide the greatest degree of professional competence available.

Information in this column was furnished to *The Journal* by personnel of the Ohio Department of Public Welfare.

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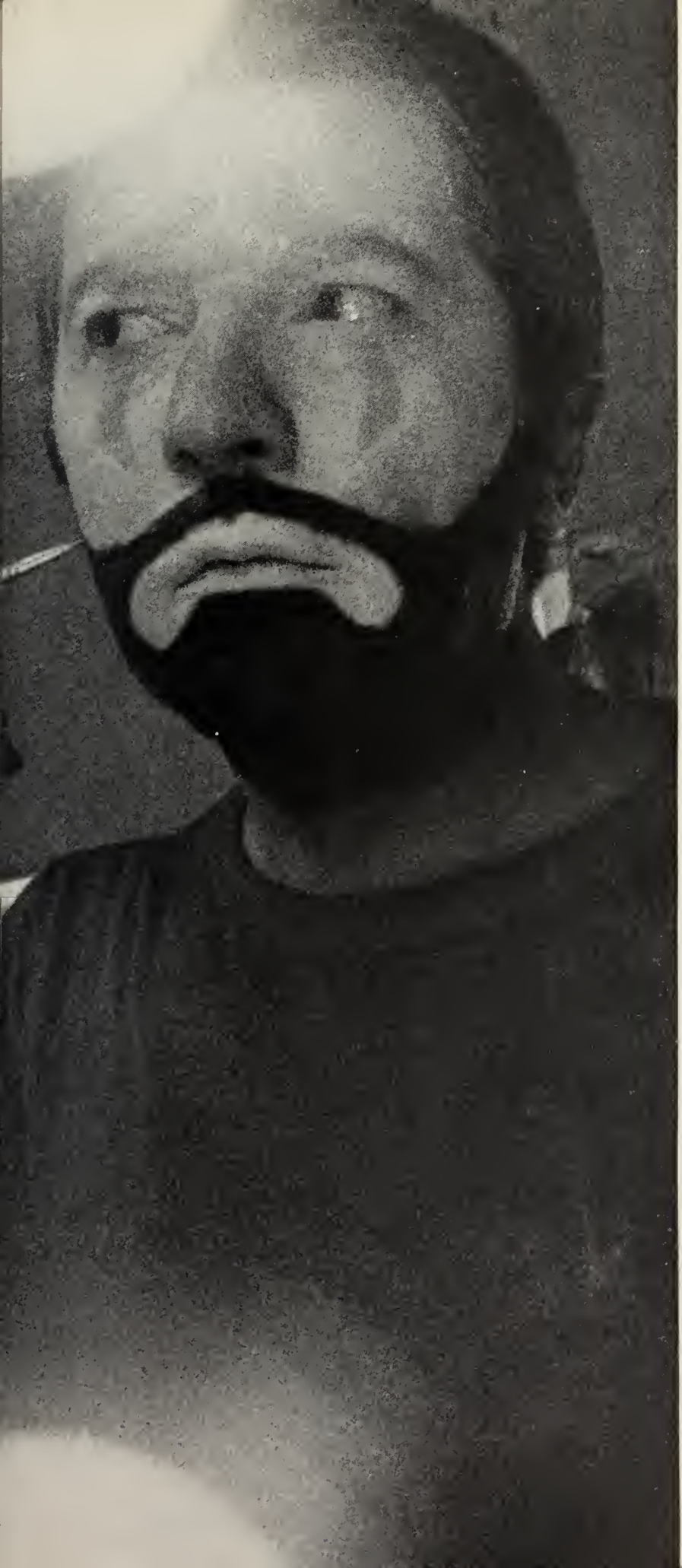
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Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

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with
Dartal® 5 mg.
(thiopropazate dihydrochloride)

Indications: Peptic ulcer, spastic constipation, nonspecific gastritis, functional gastrointestinal disorders, pylorospasm, hyperhidrosis, irritable bowel syndrome, mucous or ulcerative colitis, functional diarrhea.

Contraindications: Glaucoma, severe cardiac disease.

Warnings: Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

Adult Dosage: One tablet three times a day.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Phenobarbital 15 mg.

Warning: May be habit-forming.

For *Indications, Contraindications, Precautions, Side Effects* and *Dosage* see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro-Banthine P.A.®
prolonged acting brand of propantheline bromide

For *Indications, Contraindications, Precautions* and *Side Effects* see Pro-Banthine.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

Dosage: The recommended initial dosage is one tablet in the morning and one at night.

084

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Outstanding Scientific Exhibits at 1970 Annual Meeting

PROMINENT FEATURES of the 1970 OSMA Annual Meeting in Columbus were displayed on the exhibit floor of the Veterans Memorial Building where some 33 scientific exhibits, 18 health education, and 79 technical exhibits were presented on Tuesday, Wednesday, and Thursday of the Annual Meeting week.

Ten exhibits were selected as outstanding by a judging committee and the sponsors were presented certificates of recognition and permanent type plaques to be displayed on the exhibits and afterward kept as mementos. This procedure has been followed for a number of years upon recommendation of the Committee on Scientific work with the approval of The Council.

An illustrated summary of six of the outstanding exhibits was presented in the August issue of *The Journal*, beginning on page 944. Following is a resume of the other four exhibits judged as outstanding.

Exhibit on Anatomy of Ear Given Gold Award

The Gold Award in Teaching was presented to sponsors of the exhibit "3D Microanatomy of the Ear," sponsored by David J. Lim, M.D., and W. C. Lane, of the Department of Otolaryngology, Ohio State University College of Medicine.

This exhibit provided six stereo viewers with individual tape recorders to demonstrate a three dimensional view of the middle and inner ear structures.

The first part showed the cellular details of the middle ear mucosa. Distribution of the ciliated and secretory cells could be appreciated through this illustration.

The second part involved the cochlear sensory epithelium showing delicated and regular patterns of the sensory hairs. These are arranged in rows, some with staircase arrangements.

The third part consisted of the vestibular organs. These views showed the vestibular sensory epithelium with sensory hairs resembling church organ pipes. A viewer could proceed through the various phases of the course in nine to ten minutes.

In addition, illuminated panels composed of individual photographs with accompanying legends gave information in greater detail.

Exhibit on Transplantation Complications Awarded

The Bronze Award in Original Investigation was presented to sponsors of the exhibit entitled "Clinical Complications Following Renal Transplantation," sponsored by Donald G. Vidt, M.D., William Kiser, M.D., and Sharad Deodhar, M.D., of the Cleveland Clinic Foundation.

This exhibit reviewed the many clinical complications observed during six years of transplantation experience at the Cleveland Clinic. The more common complications frequently associated with immunosuppressive therapy were presented along with the more complicated conditions. Particular emphasis was placed upon those complications associated with oliguria or fever. The importance of early differential diagnosis was stressed so that appropriate therapy may be instituted. The exhibit included statistical data in regard to survival.

Exhibit on Drug Complications in Renal Transplantations

The Silver Award in Original Investigation was presented to the exhibit entitled "Cutaneous Complications of Immunosuppressive Therapy" sponsored by the following team from the Cleveland Clinic: Wilma F. Bergfeld, M.D., James G. Ryan, M.D., Henry H. Roenigk, Jr., M.D., Satoru Nakamoto, M.D., Sharad D. Deodhar, M.D., and Richard R. Evans, M.D.

The exhibit reviewed the cutaneous complications of immunosuppressive therapy in the treatment of 215 renal transplant patients. The immunosuppressive agents were prednisone, imuran, antilymphocytic globulin, and actinomycin C..

Sponsors of the exhibit pointed out that the vast majority of cutaneous lesions may be classified as infectious disorders of bacterial, fungal, and viral etiology. The remaining lesions are represented by neoplasms, hypersensitivity reactions, blood and vascular, and miscellaneous disorders.

A feature of the exhibit presented a clinical evaluation of the complications in Methotrexate

Outstanding Exhibits Recognized



The Gold Award in Teaching went to the exhibit, "3 D Microanatomy of the Ear." 1969-1970 OSMA President Robert N. Smith holding the Gold Award plaque, poses with two members of the team which manned the booth, Anne E. Goldfein, left, and Joan E. Lanning.



Dr. Jerry L. Hammon, member of the Committee on Scientific Work, presents the Bronze Award in Original Investigation to Dr. Donald G. Vidt, of Cleveland, one of the sponsors of the exhibit, "Clinical Complications Following Renal Transplantation."

Outstanding Exhibits Recognized



Sponsors of the exhibit "Cutaneous Complications of Immunosuppressive Therapy" were presented the Silver Award for Original Investigation." Dr. James S. Taylor, left, member of the team which manned the exhibit, holds the plaque just presented by Dr. Oscar W. Clarke, member of the Exhibit Judging Committee.



The health education exhibit entitled "Utilization Review by Length of Stay" was given Honorable Mention by the Judging Committee. James L. Henry, M. D., sponsor, adjusts projection equipment used to present the utilization review message. With him are Robert Schontzler and Juanita Rogers, R. N., both utilization review experts with Blue Cross of Central Ohio, who helped man the booth.

therapy in 204 severe psoriasis patients who were treated with Methotrexate 25 mg. orally at weekly intervals.

Utilization Review Exhibit Honored

Honorable Mention was given the health education exhibit entitled, "Utilization Review by Length of Stay," sponsored by James L. Henry, M.D., and the Academy of Medicine of Columbus and Franklin County.

This exhibit was presented for the express purpose of familiarizing physicians and hospital personnel with a successful scientific approach to utilization review. Both the Columbus Academy and the Ohio State Medical Association advocate that the length of stay by disease entity concept of utilization review is the most effective system. This exhibit demonstrated the mechanics and necessary background information required this method of peer review.

Mount Carmel Hospital of Columbus, Blue Cross of Central Ohio, and physicians of the Academy provided knowledgable trained personnel to man the booth and supplement instructions for persons who showed interest in the presentation.

The reader may wish to refer to the article, "Role of the County Medical Society in Hospital Utilization Review," by Dr. Henry in the February issue of *The Journal*, beginning on page 170.

State Bureau of Workmen's Compensation Needs Physicians

There is a critical need for physicians in the Medical Department of the Ohio Bureau of Workmen's Compensation and the medical administrator is anxious to interview physicians who would be interested in full-time employment, regular business day hours, and other benefits.

The table of organization calls for 20 physicians working full time in the Columbus office or in various branches throughout the state. The number of physicians employed at the present time is much below that level with the result that action on claims is delayed.

Physicians who know of friends who perhaps would like to limit their hours to a regular working day are requested to call this information to their attention. Physicians interested should contact O. L. Coddington, M.D., Medical Administrator, Bureau of Workmen's Compensation, 65 South Front Street, Columbus 43215.

Toledo Medical College to Combine New Surgical Intern-Residency Program

In a departure from the traditional surgery internship, the Medical College of Ohio at Toledo will introduce a two-year coordinated block of training to cover internship and the first year of residency in surgery. Eight doctors will be chosen for the initial group to begin the program in July, 1971.

According to Dr. Marion C. Anderson, chairman of the Department of Surgery and chief of surgery at the Medical College hospital, the experimental program is designed to reduce the total time needed after medical school to complete general surgical training.

The program will consist of a series of two- to four-month assignments, plus electives, spanning the 24-month period. It is an outgrowth of the tendency for doctors to prefer "straight" internships, where they remain in a specific field, over the "rotating" internship which gives them a sampling of many fields.

The schedule for the first year in the new program calls for two-month assignments in urology, orthopedics, trauma, and chest surgery, and four months in general surgery.

In the second year, the trainee will take four months in pathology and two months each in neurosurgery, plastic surgery, anesthesiology, and an elective.

Schedules are being drawn so that the young doctor will be completely responsible for basic work with the patients on his service. However, he will report to, and call upon, the senior resident and faculty surgeons for needed guidance.

"The two year program," Dr. Anderson said, "will afford a broad exposure to fundamental surgical principles in preparation for further training in either general surgery or one of the surgical specialties."

The training program will be conducted at both Maumee Valley and St. Vincent Hospitals. There is a possibility of additional assignments at Mercy Hospital and the Receiving unit of Toledo State Hospital. These avenues are still being explored, Dr. Anderson said.

Case Western Reserve Affiliates with Additional Hospitals

Affiliation of Case Western Reserve School of Medicine with Mt. Sinai and St. Luke's Hospitals of Cleveland has been approved by the boards of trustees of the three institutions and to go into effect during the current academic year, it was announced recently by CWRU President Robert W. Morse, Samuel S. Kaufman, president of the Mt. Sinai board, and E. Colin Baldwin, chairman of the St. Luke's board. The agreement adds appointed members of the hospital staffs to the medical school faculty and makes available some 1,100 additional beds for the clinical education program of the school, to provide for expanding enrollment.

While the traditional autonomy of each hospital is retained, the agreement represents a commitment by the school and hospitals to approach common objectives in medical education, patient care and research, and formalizes the cooperation which has existed between both hospitals and the school for many years.

Directors of the undergraduate teaching programs in the hospitals nominate members of their teaching staffs, subject to approval of the medical school faculty. In the past, many staff members of both hospitals were faculty members, but did their teaching at the school and at other affiliated hospitals. Students now are able to obtain clinical training at both hospitals.

Programs of collaboration between the schools and the hospitals presently are being conducted in medicine, pathology, radiology and psychiatry; these are being expanded to include other departments and services, it is stated in the agreement.

The CWRU School of Medicine is also affiliated with University Hospitals, Cleveland Metropolitan General, Highland View, Sunny Acres and Cleveland Veterans Administration Hospitals, representing a total of over 3,000 beds; in addition it is affiliated with the Cleveland Hearing and Speech Center, and students are involved in optional programs at the Oberlin Clinic and with the Cleveland Department of Health. For years both Mt. Sinai and St. Luke's have conducted teaching programs for interns and residents and at the postgraduate level.

The process of affiliation of the CWRU medical school with Mt. Sinai and St. Luke's was initiated by Dean Frederick C. Robbins, and negotiations have been under way for the past year, with Dr. Daniel L. Horrigan, Dr. Joseph M. Foley, Dr. A. Brian Little, Dr. LeRoy W. Matthews and Associate Dean Samuel Whitman representing the medical school, Dr. Herbert J. Weiss, Dr. Barry Friedman, Dr. Mortimer Lubert, Dr. Victor Vertes and Sidney Lewine, director, representing Mt. Sinai and Dr. George W. Wright, Dr. John R. Boyd, Dr. Donald M. Glover, Dr. Robert O. Walton and Kenneth J. Shoos, director, representing St. Luke's.



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Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

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Quinamm™ Specific therapy for night leg cramps
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Investment Prognosis

By Frank Van Holte, Columbus

IT IS A PLEASURE to confirm the symptoms you have observed, that the recovery of the stock market is broadening. What is remarkably meaningful to me is the strong Big Board volume which is now evident. This means that many institutional and individual investors are returning to the market. The shock of the bear market is wearing off and the many disenchanted investors are beginning to believe the signs of a break in the market. They are grabbing the bargains found in the lows of a bear market. I have not changed my basically conservative stance of accumulating stocks with sound values. This is not a time for gambling, and we should stick to strong equities. As an example, many utilities are attractively priced today.

Speaking of utilities, a shareholders' letter, issued recently by the Cincinnati Gas & Electric Company indicated that the new Riverfront Stadium in Cincinnati will give an important boost to the revenues of the Company. The lights at the new stadium produce nearly as much light as all the street lights in the City of Cincinnati, and almost six times as much as the lights of the old Crosley Field. In addition, CG&E will benefit from increased sales to commercial establishments before and after the games. Cincinnati Gas & Electric Company Common Stock would be an attractive addition to your portfolio, and this is the kind of stock you should buy at this time.

For Federal Tax purposes, "gross income" means all income from whatever source, except for those items specifically excluded by the Code (Code Sec. 61). All of us are familiar with the more common type of "gross income," such as compensation for services, interest income, dividends, annuities, etc. If you are not completely familiar with all the kinds of "gross income" your accountant helps you to list the income of particular interest to Uncle Sam.

I was interested to read in a copy of the 1970 *Master Tax Guide*, a check list of 79 types of taxable income. Of course, the list includes income from sources which are farfetched as far as you and I are concerned. Who do you know who has to report gambling winnings, prizes won at contests, rewards, and interest received on a refund of federal taxes? It is obvious, however, that the net spread by Uncle Sam is large and extensive, and it captures almost all kinds of income. However, there are a few holes in this net, and I want to remind you of at least one important source of income available to all taxpayers, which is not classified as income for tax purposes. This exempt income is "Interest on bonds of a State, City, or other political subdivision." And what makes this hole in the net particularly significant is the fact that yields on municipal bonds are at an all time high.

In addition to the tax-free appeal of municipal bonds, they also offer other attractive investment features. For example, the security of such bonds is generally considered to be second only to bonds of the U.S. Government, and the diversity of issues and maturities enables you to obtain bonds issued by an issuer located in the geographical area of your preference, and maturing at the time you wish.

Doesn't it make sense to look at municipal bonds? Call your broker and let him show you a variety of these bonds. There are "general obligation" bonds, "revenue" bonds, and other types with a variety of yields and maturities. Compare the interest income available from such bonds with the interest (after taxes) income you are receiving from other kinds of investments or from savings accounts. Or, to put it another way, check the taxable equivalent yields which taxable securities must earn in your tax bracket to equal the yield of municipal bonds. If your broker cannot offer you this service, discuss this question with an investment banker who buys and sells municipal bonds. They can show you some comparisons that will shock you.

This monthly feature is written exclusively for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Relative Cost of Medical Care

OSMA Presents Medical Cost Figures in Perspective Before Legislative Study Committee on Consumer Affairs

FOLLOWING ARE SOME FIGURES relative to the cost of medical care. In presenting this data, it is important that we emphasize the distinction between health care and medical care. Medical care includes only the services of a physician. Health care includes not only the physicians' fees but also all other items in the health care complex such as hospital charges, nursing care, prescriptions, etc. These terms have been misrepresented frequently, with "health care costs" wrongly identified as "medical care costs."

It is true that physicans' fees have increased in recent years, as have the cost of most products and services. However, the comparison of increases in physicians' fees with "all items" in the Consumer Price Index is hardly fair inasmuch as "all items" includes manufactured items. Physicians' fees are more properly associated with "all service items."

The following tabulation gives you an indication of the relative increases of physicians' fees with other service items from 1964 through 1969.

Price Increases in Services 1964-1969

	Amount of Increase
Lawyers fee—Drawing a Will	33.4%
Physician Fee—Office visit	37.8%
Auto Insurance	38.1%
Replacing a sink	40.2%
Laundry Bill	42.3%
Repairing a Furnace	44.3%
Repainting a Room	50.4%
Hospital Room—semi-private	86.0%

Comparative increases obviously depend upon the base year selected. Here is another comparison using 1962 as a base in which one will observe that physicians' fees have increased at about the same rate as postal rates and men's haircuts.

Selected Service Items for Consumer Price Index April 1970 vs 1962 (1957-59 = 100)

Item	1962	April 1970	% Increase
Postal Rates	114.1	165.5	45.0%
Men's hair cuts	109.9	159.7	43.3
Physicians' fees	111.9	164.3	46.8
Reshingling roof	112.1	165.6	47.7
Repainting rooms	107.9	187.9	74.1
Hospital (semi-private) room	127.9	279.1	118.2

Many people are of the opinion that physicians' services comprise the major cost of health care. In the fiscal year ended July 1, 1969, the national health expenditures for the U.S. were $60.3 billion. Of this amount, $22.5 billion, or 37.3 percent, were expended on hospital care; $11.9 billion, or 19.7 percent, on physicians' services.

Misleading reports by persons in government and in the news media have also led many to believe that physicians received the majority of the money expended in the Medicare and Medicaid programs. In the expenditures for health services and supplies under public programs in the fiscal year 1969, hospitals received almost 56 percent, and physicians received only 13.4 percent.

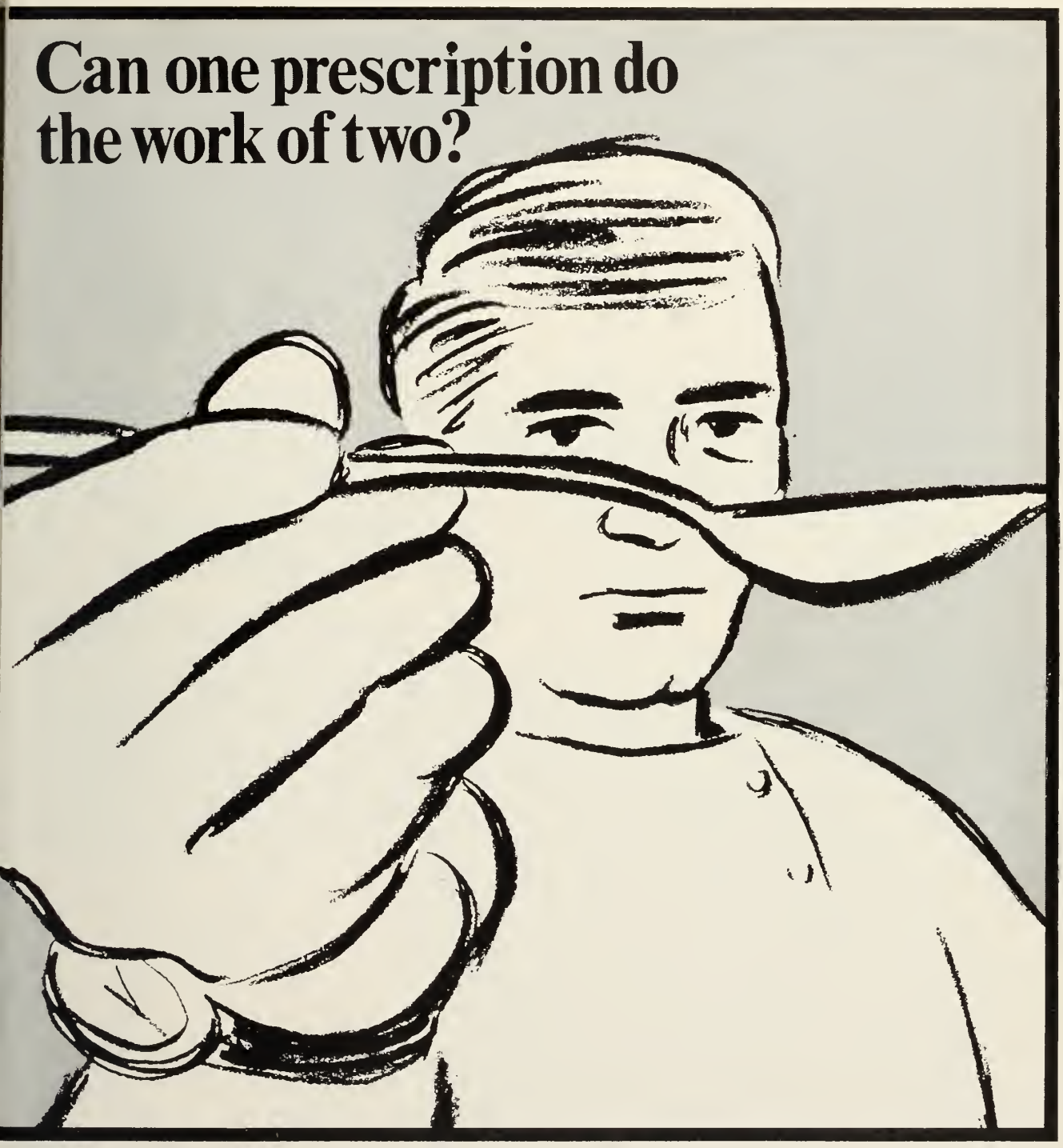
Those who are critical of physicians' incomes are inclined to ignore their long hours worked, or the high earnings of other workers. In 1969, physicians worked an average of 63 hours per week. If one adjusts the physician's median income, on the basis of time and a half for more than 40 hours per week, he would be receiving a little more than $21,000 per year for a 40-hour week. This income does not include the fringe benefits received by the salaried worker, and which are not available to the physician.

Under current New York construction contracts, a sheet metal worker could earn $51,802 a year if he worked as long as the average M.D., and a carpenter could earn $48,793.

Those interested in protecting the consumer are not likely to find much for concern in the investigation of drugs and prescription prices. According to the Consumer Price Index at the end of 1969, drugs and prescriptions were 99.2 percent of their 1957-59 level. It is true that the average prescription cost is now $3.68 per prescription, which is 54¢ more than it was ten years ago. However, six out of ten of the pharmaceutical drug prescriptions were not available ten years ago. Ten years ago, prescriptions and over the counter drug products took 16.4 percent of the total health care dollar. Today they take only 13.3 percent, and it is estimated that prescription drugs now only account for 9.3 percent.

The Ohio resident in need of medical care already has protection from overcharging. Each county society has a review committee which

Can one prescription do the work of two?



Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

Merrell

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evaluates claims of overcharging whether the complaint is filed by a private patient on his own initiative, or by a third party such as an insurance company, the federal government (on Medicare charges), or the state government (on Medicaid charges). If the complaining party feels that he or she has not had satisfaction, the case may be appealed to the Council Review Committee of the Ohio State Medical Association. This Council Review Committee will then make a recommendation to the OSMA Council, who will then make a determination.

Ohio State Medical Association members established this mediation service on their own initiative, and voluntarily agree to accept the results.

Inversely, the complainant is not obligated to accept the results.

This article was prepared by Charles F. Price, Director of the OSMA Department of Economic Research and was presented as testimony before the Subcommittee on Goods and Services of the Ohio General Assembly Legislative Study Committee on Consumer Affairs, on August 21, 1970.

painless intramuscular therapy for calcium deficiencies:

Calphosan®

calcium glycerophosphate, calcium lactate

To bring effective calcium therapy to the patient, Calphosan may be administered intramuscularly . . . without pain, inflammatory reactions, induration or sloughing. Injections twice weekly for a series of 5 to 10 injections are recommended.

Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

Write for free copy of "Calcium: The Ubiquitous and Essential Element" and for samples.

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ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES

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The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



ANTROCOL®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

SUPPLIED
Tablet in bottles of 100, 500 and 5000
Capsule in bottles of 100, 500 and 1000

Caution: Federal law prohibits dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



8—After 11 days of treatment. ema is seen at site of keratoses. In on, numerous lesions not apparent to therapy have become manifest arply defined reactions. Intervening also treated, shows no response to py.

'69—One year after cessation of py. Skin appears clear with no evi- of scarring. Examination reveals of recurrence or the formation of esions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

ROCHE Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

KEEPING UP:

Continuing Education Opportunities for Physicians in Ohio

October

American Institute of Ultrasound in Medicine, 15th annual meeting, Sheraton-Cleveland Hotel, Cleveland, October 12-15; program chairman, Adnan Sokollu, Sc. D., Office of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

Cleveland Course in Pulmonary Disease, Second Annual, St. Luke's Hospital, Cleveland, October 14-15; sponsored by Case Western Reserve University, the Tuberculosis and Respiratory Disease Association of Cleveland, the Ohio TB and Health Association, and the American Thoracic Society. Write Department of Postgraduate Medical Education, Case Western Reserve University, 2109 Adelbert Road, Cleveland 44106.

A Day of Cardiology — Ohio State University College of Medicine, Columbus; October 16, beginning at 9:00 a.m.; contact Arnold M. Weissler, M.D., Department of Medicine, 410 W. Tenth Avenue, Columbus 43210.

Current Therapy — Seminar sponsored by the Scioto County Medical Society and the Portsmouth Academy of General Practice, 705 Court Street, Portsmouth, 1:00 p.m., Thursday, October 22; contact Mr. Lowell E. Thompson, Executive Secretary, 1805 27th Street, Portsmouth 45662.

GI Bleeding — At Good Samaritan Hospital, Cincinnati; sponsored by the University of Cincinnati College of Medicine and CONMED: October 22.

A and B Blockers — A and B Stimulators (Pharmacology Series) — Youngstown Hospital Association; October 26; Dr. W. H. Bunn, Jr., and Dr. G. A. Dewan.

Anatominical Aspects of Chronic Respiratory Disease with Clinical Pathological Correlations — Trumbull Memorial Hospital, Warren, luncheon program, October 27; Jerome Kleinerman, M.D., head, Department of Pathology Research and Clinical Pathology, St. Luke's Hospital, Cleveland, and associate clinical professor of pathology, Case Western Reserve University.

Current Practices in the Care of the Newborn — Sponsored by the University of Cincinnati College of Medicine and CONMED, at the Childrens Hospital, Elland Avenue, Cincinnati; October 28.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Convocation on Medicine and Theology — Netherland Hilton Hotel, Cincinnati, October 29, 9:00 a.m. to 4:00 p.m.; sponsored by West Ohio Conference for Clergy and Physicians; contact the Rev. Bruce McClure, Bethesda Hospital, Oak and Reading Road, Cincinnati 45219.

Introductory Course in Nuclear Medicine for Physicians — Nuclear Medicine Institute, 6760 Mayfield Road, Cleveland 44124; contact for dates.

November

Hematology Seminar — Veterans Administration Center, 4100 W. Third Street, Dayton, 8:00 a.m. to 4:30 p.m., November 4. Contact R. G. Belliard, M.D., Chief, Hematology Section, at the center.

Testing Skill Workshop — At the Christopher Inn, Columbus, November 1; sponsored by the Ohio Academy of General Practice.

Ob-Gyn Conference — Sponsored by Ohio State University College of Medicine at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, November 4.

The Prevention of Birth Defects and Mental Retardation — Sponsored by the Children's Medical Center, 1735 Chapel Street, Dayton 45404, on Wednesday, November 4 from 10 a.m. to 5 p.m. at the Imperial House North Motel, Dayton.

Congress of County Medical Societies, 1970 Meeting, Netherland Hilton Hotel, Cincinnati, November 6-8; approved for 12 credit hours by AAGP; contact M. Robert Knapp, M.D., 4 Peachtree Lane, Wichita, Kansas 67207.

Isotopes in Clinical Medicine (Pharmacology Series) — Youngstown Hospital Association; November 9; Dr. H. N. Bennett and Dr. P. Javean.

(Continued on Next Page)

Educational Opportunities in Ohio—*Continued*

Eye Conference — Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus; November 9-10; for specialists.

New Horizons in Reproductive Physiology and Pathology — St. Ann Hospital, 2475 East Blvd., Cleveland 44120, November 11.

Diagnostic Procedures in Gastroenterology — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; November 11-12.

Neurology Conference — Sponsored by Ohio State University College of Medicine, at OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, November 20.

Chemotherapy in the Patient with Incurable Cancer (Pharmacology Series) — Youngstown Hospital Association; November 23; Dr. W. D. Loeser and Dr. M. Kuangparichat.

Inappropriate Breathlessness — Dyspnea — Trumbull Memorial Hospital, Warren, luncheon program, November 24; George W. Wright, M.D., head, Department of Medical Research, St. Luke's Hospital, Cleveland, and associate clinical professor of medicine, Case Western Reserve University.

December

Obstetrics and Gynecology — Sponsored by the University of Cincinnati College of Medicine and CONMED, at Christ Hospital, Elland Avenue, Cincinnati, December 3.

Ocular Surgery, Glaucoma and External Disease — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland; December 9-10.

Spinal Cord Injuries Conference — Ohio State University College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, December 10.

Electrolyte and Fluid Balance — At Jewish Hospital, Cincinnati; sponsored by the University of Cincinnati College of Medicine and CONMED; December 10.

New Antibiotics — Gentamycin, Carbentocillin and Others (Pharmacology Series) — Youngstown Hospital Association; December 14; Dr. G. A. Butcher and Dr. J. Conti.

January

Fifty Years of Surgical Progress—Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; January 13-14.

Recognition, Evaluation, and Control of Occupational Hazards — Training Institute, Environmental Control Administration, 1014 Broadway, Cincinnati 45202; January 18-22.

Orthopaedic Challenges — Reconstructive and Post-Traumatic — Cleveland Clinic Educational Foundation, January 20-21.

Selected Aspects of General Medicine — Sponsored by the University of Cincinnati College of Medicine and CONMED, Eden Avenue, January 20-21.

New Endoscopic and Camera Techniques (Gastroenterology Series) — Youngstown Hospital Association, January 25.

Tests of Pulmonary Gas Transfer—Clinical Problems of O_2 - CO_2 Exchange — Trumbull Memorial Hospital, Warren, luncheon program, January 26; Edward H. Chester, M.D., head, Pulmonary Section A, Veterans Administration Hospital, Cleveland, and assistant professor of medicine, Case Western Reserve University.

New Developments in Special Procedures, Complications and Legal Implications — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; January 27-28.

February

General Practice — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, February 3-4.

Hospital Infection Control — Sponsored by the University of Cincinnati College of Medicine and CONMED at the Shriners Burns Institute Auditorium and Cincinnati General Hospital, February 4.

Hepatitis: Subacute Hepatitis, Chronic Active Hepatitis (Gastroenterology Series) — Youngstown Hospital Association, February 8.

Disorders of the Red Cell — Cleveland Clinic Educational Foundation, February 10-11.

Facial Fractures — Repair and Plastic Surgery — Sponsored by the University of Cincinnati College of Medicine and CONMED at the Shriners Burns Institute Auditorium and Cincinnati General Hospital, February 15-19.

Granulomatous and Nongranulomatous Colitis (Gastroenterology Series) — Youngstown Hospital Association, February 22.

Physiologic Bases of Assisted Ventilation — Applied Respiratory Mechanisms — Trumbull Memorial Hospital, Warren; luncheon program, February 23; John J. Picken, M.D., instructor in medicine, Case Western Reserve University.

Electromyography — Ohio State University College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, February 23-25.

Review of the Connective Tissue Diseases by Systems. Manifestations and Management — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; February 24-25.



Exhibits Wanted

1971 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association is just the place to display it. We are now accepting applications for the 1971 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be May 11, 12 and 13.

Mail application to the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1971 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, Ohio, May 10-14

1. Title of Exhibit: _____
2. Name(s) of Exhibitor(s): _____

   Institution (if desired): _____

   City _____
3. Do you have a built-in exhibit? _____
4. Booth Requirements: Back wall _____ (indicate footage) All sidewalls are 6′ deep
5. Description of Exhibit: (Attach 200 word description to this blank)

Deadline For Filing Applications, February 1, 1971

ON THE OMPAC FRONT

Vital Implications in the Coming Election

"The importance of this year's election in the state legislative arena is greatly magnified, since the party winning control will have an opportunity to redraw Congressional district boundaries in many states . . . Many state PAC's are according greater emphasis on these important legislative races," *Political Stethoscope,* publication of the American Medical Political Action Committee.

This is exactly the situation in Ohio. The emphasis being given by the Ohio Medical Political Action Committee to efforts to elect a large number of well-qualified candidates for seats in the Ohio General Assembly is only part of the story, however. Between now and the November Election, lots of talk and door bell ringing on behalf of these candidates by physicians, physicians' wives and others interested in good government and sound legislation will be necessary. Those who may wish to know about the qualifications or record of candidates will be able to obtain that information from the Legislative Committee of their county medical societies or from the headquarters office of the Ohio State Medical Association.

Inflation and recession will be two of the major issues in this election year, according to the political prophets. Doubtless, they are correct. However, the issue of national health insurance can't be overlooked—at least so far as the medical profession is concerned. Physicians should find out how candidates—new and incumbents—stand on national health insurance in addition to the prevailing economic and social issues. One good way to find out and get the answer from the horse's mouth is to ask the candidates themselves—before the election when candidates are in a more flexible mood, perhaps, than after the votes are counted.

* * * *

OMPAC's books are still open, meaning that it is not too late for those who have not made a 1970 contribution to do so. Now is the time when candidates tapped by OMPAC need as much financial help as OMPAC is able to give them.

Ohio Medical Political Action Committee

★

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A. C. Spath, Jr., R. A. Zimmermann

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter

Obituaries

Benedict Bernard Backley, M.D., Louisville, Ky.; Ohio State University College of Medicine, 1935; aged 65; died August 4; member of the Ohio State Medical Association, the American Medical Association, and the American Geriatrics Society; practitioner in the Lakewood area before his retirement, and formerly health commissioner in Athens County; last rites from the Catholic Church; survived by his widow, two daughters, a son, three sisters, and two brothers.

Roy Barnwell, M.D., formerly of Cuyahoga Falls; St. Louis University School of Medicine, 1917; aged 80; died August 21 in Millington, Tenn.; resident and practitioner in the Cuyahoga Falls area for more than 50 years; formerly associated with Akron hospitals; member of the Kiwanis Club, Methodist Church, the Masonic Lodge; active in a number of community projects such as the Boy Scouts; veteran of World War I; survived by a son and a sister.

Reuben Jacob Boesel, M.D., Cheyenne, Wyoming; Ohio State University College of Medicine, 1921; aged 75; died August 8; formerly practiced for a short time in Southern Ohio; resident of Wyoming since 1931.

Arthur Edward Cone, M.D., Toledo; University of Michigan Medical School, 1920; aged 75; died August 24; member of the Ohio State Medical Association and the American Medical Association; Toledo physician and surgeon for 50 years; survived by his widow, a daughter, and four sons.

Frederick Arthur Euler, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1911; aged 83; died July 21; practitioner for many years in Cleveland; veteran of World War I; member of the Masonic Lodge.

Howard D. Fabing, M.D., New Richmond; University of Cincinnati College of Medicine, 1932; aged 63; died July 29; member of the Ohio State Medical Association, the American Medical Association; American Neurological Association, American Academy of Neurology; American Psychiatric Association, and Central Neuropsychiatric Association; diplomate of the American Board of Psychiatry and Neurology; practitioner of long standing in Cincinnati where he specialized in neuropsychiatry; past president of the Academy of Medicine of Cincinnati; on the faculty of the University of Cincinnati College of Medicine; served in the Army Medical Corps during World War II and attained the rank of lieutenant colonel; consultant to the Army Surgeon General during Korean War; researcher and author; survived by his widow, Dr. Ester Marting Fabing, two daughters, a son, and a sister.

Benjamin Harrison Gillespie, M.D., Akron; Western Reserve University School of Medicine, 1915; aged 81; died August 25; member of the Ohio State Medical Association and the American Medical Association; physician and surgeon in Akron for virtually all of his professional career; veteran of World War I; member of the Presbyterian Church and several Masonic bodies; survived by a sister.

Aaron Isaac Grollman, M.D., Baltimore, Md.; University of Maryland School of Medicine, 1928; aged 67; died in July; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Abdominal Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Radiology; practitioner of long standing in Cincinnati; veteran of World War II.

Morton Hamburger, M.D., Cincinnati; Johns Hopkins University School of Medicine, 1934; aged 63; died July 28 from accidental drowning while vacationing in Wyoming; member of the Ohio State Medical Association, the American Medical Association, American Society of Internal Medicine, Central Society for Clinical Research, and numerous other professional organizations; Fellow of the American College of physicians; diplomate of the American Board of Internal Medicine; practitioner of long standing in Cincinnati; member of the Faculty of the University of Cincinnati College of Medicine; on the editorial board of *The Archives of Internal Medicine* and that of *Antimicrobial Agents and Chemotherapy;* field director during World War II of the Commission on Air Borne Infections, Armed Forces Epidemiology Board; survived by his widow, two sons, a daughter, a brother, and a sister.

Thomas Wellington Howell, M.D., Mansfield; Jefferson Medical College of Philadelphia, 1937; aged 56; died March 29; member of the Ohio State Medical Association, the American Medical Association, Aerospace Medical Association, Industrial Medical Association, American Academy of Occupational Medicine, and the American Society of Internal Medicine; practi-

tioner in Mansfield, specializing in industrial medicine; military officer with the rank of colonel; survived by his widow.

L. Courtney Jack, M.D., Cincinnati; University of Cincinnati College of Medicine, 1934; aged 61; died August 2; member of the Ohio State Medical Association and the American Medical Association; practitioner in Cincinnati; retired in recent years for health reasons; veteran of World War II.

Adelbert Marion Mills, M.D., Ashtabula; Western Reserve University School of Medicine, 1929; aged 67; died August 28; member of the Ohio State Medical Association, the American Medical Association, the American Academy of General Practice, and the Aerospace Medical Association; native of Ashtabula and practitioner there since 1931, specializing in obstetrics and gynecology; veteran of World War II; past president of the Ashtabula County Medical Society; member of the Presbyterian Church, the Kiwanis Club, Chamber of Commerce, YMCA, Elks Lodge; survived by his widow, a son, a daughter, two brothers.

John Joseph Phair, M.D., Cincinnati; University of Cincinnati College of Medicine, 1929; aged 66; died August 9; member of the Ohio State Medical Association, the American Medical Association, American College of Preventive Medicine, Aerospace Medical Association; Fellow of the American College of Physicians; diplomate of the American Board of Preventive Medicine; clinical professor of preventive medicine at the University of Cincinnati College of Medicine and associated for many years with the Cincinnati Department of Health; served on several national and international commissions dealing with health; author of many professional articles and several texts; survived by his widow, a son, Dr. John P. Phair, and a sister.

John Timothy Quirk, M.D., Piqua; St. Louis University School of Medicine, 1924; aged 72; died August 11; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Physicians; native of Piqua and practitioner there for many years, specializing in cardiology; member of the Catholic Church; survived by a sister.

Fabio Rodriquez, M.D., Canton; Faculty of Medicine, University of Santo Domingo, 1945; aged 50; died July 28 while traveling in Spain; member of the Ohio State Medical Association, the American Medical Association, and the American Society of Clinical Pathologists; Fellow of the American College of Pathologists; diplomate of the American Board of Pathology; native of the Dominican Republic and practitioner there until 1952; formerly pathologist for Aultman Hospital and acting Stark County coroner; in private practice since 1961; survived by his widow, four sons, and a daughter.

Ralph Allen Scherz, M.D., Riverside, Calif.; Cleveland-Pulte Medical College, 1908; aged 86; died August 5; member of the Ohio State Medical Association and the American Medical Association; general practitioner on the West Side of Cleveland for 52 years before his retirement in 1961.

Albert Louis Steinfeld, M.D., Toledo; Johns Hopkins University School of Medicine, 1901; aged 93; died July 26; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology; Fellow of the American College of Surgeons; practitioner in Toledo from 1901 until his retirement in 1961, specializing in ophthalmology and otolaryngology; veteran of World War I; member of the Collingwood Avenue Temple; survived by a daughter.

Thomas Patrick Wangler, M.D., Columbus; Ohio State University College of Medicine, 1932; aged 63; died August 16; member of the Ohio State Medical Journal and the American Medical Association; general practitioner in Columbus for 37 years; member of the Catholic Church and active in Catholic men's organization work; member of the Columbus Maennerchor; survived by his widow, a daughter, a son, two brothers, and three sisters.

Second Family Practice Examination Scheduled

The American Board of Family Practice announces that it will give its SECOND examination for certification in various centers throughout the United States. The examination will be over a two-day period on February 27-28, 1971. Information regarding the examination and eligibility for the examination can be obtained by writing:

Nicholas J. Pisacano, M.D., Secretary-Treasurer,
American Board of Family Practice, Inc.,
University of Kentucky Medical Center,
Annex #2, Room 229,
Lexington, Kentucky 40506.

Deadline for receiving completed application in the Board office is November 1, 1970.

OSU Dean Named Vice-President for Medical Affairs



Dr. Meiling

PRESIDENT NOVICE G. FAWCETT of Ohio State University in mid-September announced the appointment of Dr. Richard L. Meiling to the newly created position of Vice-President for Medical Affairs.

Dr. Meiling has been dean of Ohio State's College of Medicine and director of the University Hospitals since 1961.

The appointment is effective October 1, and is subject to ratification by the university's Board of Trustees.

The vice-president for medical affairs will have responsibility for the continued planning, development and management of the University Medical Center, including the present University Hospital and $51 million in new facilities. He will be responsible also for coordination of the affiliated hospitals program, the new Mental Retardation Facility, animal laboratories, regional medical programs, the Medical Library and non-academic aspects of the College of Medicine.

Dr. Meiling has served at Ohio State for 32 years. In addition to his work in medical education, he pioneered in medical and military procedures used to save the lives of wounded servicemen. He holds both the Air Force Distinguished Service Medal and the Legion of Merit.

Dr. Meiling has served on the Hoover Commission, as representative of the United States to the World Health Organization of the United Nations, as a member of the several National Institutes of Health Councils and on the national advisory board of the American Red Cross Blood Program.

Dr. Meiling was granted a two-year leave of absence from Ohio State in 1949-51 to serve as assistant to the Secretary of Defense for Health and Medical Affairs.

Dr. Meiling is accredited as a Diplomate of both the American Board of Obstetrics and Gynecology and the American Board of Preventive Medicine (Aviation Medicine). He is a fellow and past member of the Board of Governors of the American College of Surgeons and is a Founding Fellow of the American College of Obstetricians and Gynecologists. He is a Past President of the Ohio State Medical Association, an Ohio Delegate to the American Medical Association, a member of a number of other professional societies, and is an honorary member of the Royal Medical Society of London (England).

Active in civic affairs, he has served as a member of the Board of Directors of the Columbus Rotary Club, is a past president of the Columbus Town Meeting, and a member of the Board of Trustees of the Columbus Hospital Federation. He is a trustee of Children's Hospital in Columbus..

Dr. Meiling is a native of Springfield, O. He graduated from Wittenberg University and received his medical education from Jefferson Medical College, the University of Erlangen and the University of Munich. He received the doctor of medicine degree from Munich and a doctor of science degree (honoris causa) from Wittenberg in 1950. Dr. Meiling was on the Board of Directors of Wittenberg University for five years.

After serving in the armed forces, he returned to Ohio State in 1947, serving in several faculty posts and from 1951-1960, as associate dean of the College of Medicine and associate director of University Hospital.

He began military service as a flying cadet in 1932 and rose to the rank of major general in the Air Force Reserve.

Dr. Meiling will continue to engage in the private practice of medicine on a part-time basis, specializing in obstetrics and gynecology.

Acting Dean Named

At the same time, Dr. Fawcett announced appointment of Dr. John A. Prior as acting dean of the College of Medicine. He is currently associate dean of the college and associate director of University Hospitals.

Dr. Prior, a specialist in the field of pulmonary diseases, holds a professorship in the university's department of medicine.

He is the author of more than 40 technical articles dealing with pulmonary and fungus diseases. In addition, he has written a textbook, *Physical Diagnosis,* which was published in 1959, (Third edition, 1969).

He is a diplomate of the American Board of Internal Medicine, a fellow in the American College of Physicians, and a consultant in pulmonary diseases and internal medicine for the Veterans Administration and the United States Air Force.

Addendum to Roster of Specialty Organizations

In the August issue of *The Journal* a roster of Ohio Specialty Organizations was printed on page 831. The following organization is added here as a part of that roster.

Ohio Academy of General Practice — President: Robert S. Young, M.D., Box 487, Johnstown 43031; Executive Secretary: Mrs. Florence I. Landis, 4075 North High St., Columbus 43214; Program Chairman: Carl E. Spragg, M.D., 71 West Main St., New Concord 43762.



SOME OF THE WAYS AMERICANS SPEND THEIR MONEY

Critics of physicians' fees might do well to compare the dollars paid to doctors with the amounts paid for other services and products. Consider the expenditures in the table below:

EDITOR'S NOTE: *This is one of a series of articles, the purpose of which is to inform the membership of pertinent facts about health care. The content will be intentionally brief and will present only a few significant facts in each issue. We trust that readers can thus more easily remember such information and use it as appropriate in discussions with patients and others. "Capsules" are prepared by OSMA Director of Economic Research, Charles F. Price. If you need explanation or elaboration on any of the data, please direct your requests to him at the OSMA office.*

Cincinnati Will Host Congress of Medical Societies

The Congress of County Medical Societies has announced the dates for its 1970 Annual Meeting and Seminar on Private Practice. The meetings are scheduled for November 6-7-8, 1970, at the Netherland Hilton Hotel in Cincinnati.

The program has been approved by the American Academy of General Practice for 12 elective hours of credit.

The program will feature Mr. Robert J. Myers, former Chief Actuary for the Social Security Administration, as the speaker for the Friday, November 6 banquet.

The Congress of County Medical Societies was formed in 1965 as a mechanism for the exchange of information among practicing physicians and their local medical societies. Currently, 70 county societies participate as members and more than 63,000 physicians belong to the organization, making it the second largest medical organization in the country.

The Academy of Medicine of Cincinnati will act as host for the November meeting. Dr. Richard Fulton, President of the Ohio State Medical Association, will be the keynote speaker.

Licensed physicians and all medical society personnel are invited to attend.

Mail address of the organization is P. O. Box 54571, Terminal Annex, Los Angeles, Calif. 90054, or contact may be made with M. Robert Knapp, M.D., 4 Peachtree Lane, Wichita, Kansas 67207.

Personal Consumption Expenditures By Selected Services and Products

(Billions of Dollars)

Year	Physicians' Services	Alcoholic Beverages	Tobacco	Radio and TV Receivers*
1966	$ 8.8	$13.7	$ 8.9	$6.9
1967	9.3	14.5	9.3	7.3
1968	10.2	15.6	9.8	7.9
1969	11.4	16.4	10.2	8.1

* includes records and musical instruments

SOURCE. Survey of Current Business, Page 28, issue of July, 1970.

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati, Ohio 45243

WITH SUMMER HOLIDAYS and Labor Day weekend behind us, there is evidence that auxiliaries are beginning their fall activities. Two marvelous newspaper stories complete with excellent photos tell of the first big event of the season for **Summit County** — a benefit fashion show for the Betty Dobkin Scholarship fund which aids young women in nurses' training.

What makes this an unusual affair is that both husbands and wives modeled clothes to show "The Long Lean Look of Fashion." Mrs. John Wegryn and Mrs. Paul Cheek served as chairman and cochairman of the benefit which was held at the Norton Brown Derby. With the awarding of five $400 scholarships this year, 38 girls to date have been helped in achieving their nursing goals. The awards are applied over a three-year nursing school program.

Stark County's "Capsule" newsletter arrived with a calendar of events for fall. In addition to a morning coffee in September and a luncheon meeting in October, auxilians are urged to buy their Christmas cards early and to attend workshops in preparation for an up-coming Bazaar. It was announced that $160 for AMA-ERF was won by auxiliary members who participated in the annual Gold Rush Walk, a community sponsored joint fund raising effort.

Hamilton County's committees are working well in advance of regularly scheduled monthly meetings. September was a month of action with Mrs. Robert H. Poe and Mrs. Owen L. Brown calling their workers together for Christmas card sales. Mrs. Victor H. Hinricks asked her Holiday Ball committee to meet at the Apple Tree Day Center for a first hand look at the project which will benefit financially from the fund-raising Ball.

"Salute to Thirty Years"

As part of the birthday celebration theme of the annual meeting in May, Mrs. Christopher A. Colombi compiled a history of the auxiliary. Vi's presentation cannot be adequately reproduced in print, but here are some of the interesting points she related.

"Come with us through Memory's Door to that important year of 1940. Times have changed since Ohio's auxiliary was born. War in Europe had begun. France had been beaten, the United States had gone into a huge defense program, and Wilke was the Republican choice to stop Roosevelt.

"Women looked different — the open toed shoe had arrived. The short evening dress had appeared, but had not supplanted the sweeping one. The hair was longer, the page boy cut had come . . . some women had begun to put their hair up . . .

"The Woman's Auxiliary to the Ohio State Medical Association was organized on May 15, 1940 at the Hotel Gibson in Cincinnati. Thirty-nine doctors' wives paid dues of fifty cents and elected one delegate for the national convention in New York. The first president, Mrs. J. E. Purdy, Canton, presided with a gavel made from wood from the home of President William McKinley. Scotty Saville, assistant executive secretary

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Carl F. Goll
1001 Granard Parkway
Steubenville, 43952

President-Elect
Mrs. Russell L. Wiessinger
2280 W. Wayne Street
Lima, 45805

Past President
Mrs. Samuel L. Meltzer
2442 Dorman Drive
Portsmouth, 45662

First Vice-President
Mrs. Rudolf O. Cooks
15830 Van Aken Blvd., Apt. 401
Cleveland, 44120

Second Vice-President
Mrs. Daniel Wolff
3963 W. Bancroft Street
Toledo, 43606

Third Vice-President
Mrs. H. I. Humphrey
389 S. Drexel Avenue
Columbus, 43209

Recording Secretary
Mrs. Emil L. Barrows
7181 W. Aracoma Drive
Cincinnati, 45237

Corresponding Secretary
Mrs. F. A. Sunseri
301 Woodridge Drive
Steubenville, 43952

Treasurer
Mrs. Paul Hahn
122 Moore Avenue, N.W.
New Philadelphia, 44663

of OSMA, served as secretary for the organizational meeting.

"Popular songs then were "How High the Moon?" "When You Wish Upon a Star" and "We Could Make Such Beautiful Music Together."

"Four directors covered the state in 1941, when the shadow of inflation stalked North America, and bombs fell on Pearl Harbor. Silver fox was still the queenly fur. Black was stylish, but there was still plenty of color, and there was a hint of the military in women's dress.

"In April of 1942, seven Board members and four or five committee chairmen carried on state business. Our immediate past president, Mrs. Samuel L. Meltzer, was one of these chairmen — her assignment was Public Relations! Knitting was in prominence, as *Hygeia*, a publication of the American Medical Association, was born.

"In 1943, the Doctors' Aide Corps was formed. Physicians gave intensive lectures and courses so the aides could pinch-hit . . .

"Health education as it is today became a priority in 1946 when Ohio now sent nine delegates to National Convention and started a School of Instruction.

"Two hundred and six women were elected that year to state legislatures in the United States; 325,000 women owned their own businesses; 9,000 lost money but made more than $10,000 per year.

"A recommendation was made by the State Board to publish an auxiliary publication to be sent to all physicians' wives without charge. Cincinnati performed a skit "The Girl That I Marry" at the 1948 convention. As the World Medical Association was formed in France, the Ohio State Auxiliary's Past Presidents' Gavel Club was organized with Mrs. Stevens, chairman, and Mrs. Dale Osborn, secretary. The Honorary Membership category was also established and to date we have seven honorary members.

"In October of 1949 "Worth Remembering" appeared in the Auxiliary News and I quote Mrs. Eustace A. Allen who wrote — 'You enter the world of public relations the day you marry that doctor! There is every opportunity, through friends and lay organizations, to promote the aims and ideals of public health and welfare and the Woman's Auxiliary is the perfect medium.'

"And so we leave the 40's with their worries and fears, their regulations and restrictions, and VE and VJ Days.

The Fabulous Fifties

"When nylons came back and Christian Dior introduced the new look . . . When President Truman upset the pollsters . . . a wierd new world of flying saucers, sound barriers, nuclear energy, television, wonder drugs and super markets.

"Doctors began to pay dues to AMA for the first time, as heretofore, work had been done by volunteers. Efforts were made to urge black physicians to join.

"In September 1950, District #3 met in Marion at the Hotel Harding. A hand carved gavel made from an elm in the Harding Memorial was given to the county with the best representation. In 1954 the Essay Contest of the American Association of American Physicians and surgeons succeeded for the first time in interesting many school boards.

"In the United States, President Truman announced 'full speed ahead' research on the H bomb. Cape Canaveral was only a pinpoint on the map. Suez was a Canal, not a crisis.

"The Auxiliary's fifteenth year began while we were talking about "My Fair Lady," Volkswagons, Beatniks, Diners' Club Cards and Jayne

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Mansfield. We learned new words like Hi-Fi, brainwashed, supersonic, and fallout, but to name a few.

"Salk Mass Polio programs were spectacular in many communities.

"And who can forget? *Hygeia's* name was changed to *Today's Health* . . . the 80 dimes theme for Medical Education Week — signifying the $8 each medical school was in the red for each medical student per week!

"In 1957 a state resolution was passed to ask the Ohio State Medical Association for a permanent home — which led to an annual yearly grant of $1500 from OSMA to the State Auxiliary.

"Awards were given to seven representatives of Paramedical Careers in 1959 and Trade Hats or Pennants, for identification of counties, were worn or carried at Fall Conference. Ohio Auxiliary membership moved from fourth place to third in national order and this was the first year Ohio delegates received a free breakfast from the state budget at National Convention.

The Soaring Sixties

"The soaring sixties gave us our first secretarial assistant, Mrs. Dorothy Friday. We shared the Ethel Gastineau trophy bowl and AMA-ERF honors with Tennessee. We hummed or whistled tunes from Camelot and enjoyed a year of the Twist.

"In 1961 our auxiliary was recognized and commended publicly by the State Legislature and given the privilege of designating an annual Health Careers Week for the entire state.

"Ohio had its first National Auxiliary President, Mrs. W. H. Evans of Youngstown, in 1964 . . . National dues went up to $2.00 and all members received the national magazine *MD's Wife*.

"Operation Hometown" became a big legislative project for 1963-64. "Hear Auxiliary — See Auxiliary — Speak Auxiliary" was our theme in 1965-66. The clergy and the medical profession began making a special effort to work together for the benefit of the 'whole man.'

"Our own Central Office on High Street with its own equipment and part-time secretary, Mrs. Lucile Egger, became a reality in 1967 . . . with a projected budget of $7000 for next year.

"Ohio had its second National Auxiliary President, Mrs. Karl F. Ritter, of Lima. The decade had provided several Ohioans in regional chairmanships and other offices for national.

"Mrs. S. L. Meltzer published her first novel *Falls the Shadow* with authentic references made to the history of radiology and shared a percentage of sales for AMA-ERF.

"And so we approach the solar seventies. As an auxiliary we are still sharing the age old objectives of the medical profession . . . the OSMA byword of 'Together we Care' . . . still singing that same sweet duet of 1940 . . . 'We Could Make Such Beautiful Music Together'."

Improvements Announced in OSMA-Sponsored Group Life Insurance Plan

Turner & Shepard, Inc., administrator of the Ohio State Medical Association group life insurance plan, has announced changes in the plan, including reduced premiums, cash dividend distribution, and availability of dependent insurance. These changes were approved by The OSMA Council at its July 18-19 meeting.

Because of the high level of participation and favorable claim experience, the premium rates for all members under age 60 have been reduced. This unusual action will not reduce coverages under the plan, but will provide the same protection—up to $50,000 available—as before at a lower cost to members.

The plan has also been amended to distribute all earned dividends in cash, in accordance with the wishes of the majority of enrolled physicians.

Dependent group life insurance has been added to the plan on an optional basis. It provides $5,000 coverage on the life of the member's spouse; $500 on each child between the ages of 14 days and six months; $1.000 on each child six months to 20 years of age. The amounts are the maximum permitted under current Ohio Statutes for group insurance plans.

The OSMA group life insurance plan currently has over 2,000 individuals enrolled, with insurance in force amounting to over $27,293,750. Other features of the plan are unchanged, including accidental death and dismemberment coverage, waiver of premium protection, conversion options, assignment privileges, settlement options, and eligibility. Employee coverage up to $2,000 is also available for OSMA member physicians.

The plan is underwritten by the Union Central Life Insurance Company of Cincinnati, one of the largest and oldest fiduciary institutions in the United States, with business in force of more than $4 billion.

Complete information on both the basic plans and details of the changes are available from the plan's administrator: Turner & Shepard, Inc., 17 South High Street, Columbus, Ohio 43215, telephone (614) 228-6115.

County Societies' Officers and Meeting Dates

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High St.

ADAMS—Gary J. Greenlee, President, Farmers' Bank Building, Manchester 45144; Hazel Sproull, Secretary, P.O. Box 337, West Union 45693, 3rd Thursday, April, July, Oct. and Jan.

BROWN—Robert S. Benintendi, President, South Main Street, Route 1, Box N, Georgetown 45121; Robert A. Baker, Secretary, South Main Street, Georgetown 45121.

BUTLER—John H. Varney Jr., President, 3207 Sheldon Rd., Middletown 45042; Mr. E. Clifford Roberts, Executive Secretary, P.O. Box 325, 110 North Third St., Hamilton 45011. 4th Wednesday.

CLERMONT—Kurt Platschik, President, 4450 Mt. Carmel-Tobasco Road, Cincinnati 45244; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103; 3rd Wednesday except July, August and December.

CLINTON—Arthur F. Lippert, President, 110 East Locust St., Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday.

HAMILTON—Robert S. Heidt, President, 2340 Auburn Ave., Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday, except June, July, Aug. and Dec.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson St., Greenfield 45123.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason 45040; Orville L. Layman, Secretary, 22 West Fourth St., Franklin 45005. 2nd Tuesday.

Second District

Councilor: George J. Schroer, Ft. Loramie 45845
20 S. Main St.

CHAMPAIGN—Lewis Inskeep, President, 201 Scioto St., Urbana 43078; Terrence F. Grogan, Secretary, 848 Scioto St., Urbana 43708. 2nd Wednesday.

CLARK—Wesley E. Knaup, President, 1054 East High St., Springfield 45505; Mrs. Marion Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone St., Springfield 45503. 3rd Monday, except June, July, Aug. and Dec.

DARKE—E. W. Browne, President, 330½ West Fourth Street, Greenville 45331; 3rd Tuesday.

GREENE—Rudi Sotlar, President, 12 South Limestone Street, Jamestown 45335; Mrs. W. F. Whitt, Executive Secretary, 966 Whitestone St., Xenia 45385. Last Friday of every month.

MIAMI COUNTY—Kenneth Faze, President, 3 Duerr Drive, West Milton 45383; Martha L. Derr, Executive Secretary, P.O. Box 467, Piqua 45356. 1st Tuesday.

MONTGOMERY—Robert A. Bruce, President, 1126 South Main St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building, Dayton 45402. Monthly meeting dates as established.

PREBLE—J. D. Darrow, President, 228 North Barron St., Eaton 45320; J. R. Williams, Secretary, 228 North Barron St., Eaton 45320. No regular meeting date.

SHELBY—George J. Schroer, President, 20 South Main St., Fort Loramie 45845; William F. Mentges, Secretary, 870 South Main Ave., Sidney 45365. 2nd Tuesday of March, June, September and December.

Third District

Councilor: Dwight L. Becker, Lima 45805
1559 Bunker Drive

ALLEN—Alexander C. Reed, President, 819 West North St., Lima 45801; William E. Noble, Secretary, c/o Memorial Hospital, Linden & Mobel Ave., Lima 45804. 3rd Tuesday.

AUGLAIZE—John F. Bowling, President, 1001 Knoxville Rd., St. Marys 45885; Barbara Cummins, Secretary, 310 Perry St., Wapakoneta 45895. 1st Thursday every other month, starting with January.

CRAWFORD—Horace B. Newhard, President, 140 Hill St., Bucyrus 44820; C. Fabrigar, Secretary, 139 Gaius St., Bucyrus 44820. Meeting date variable.

HANCOCK—Robert Brown, President, 868 South Main St., Findlay 45840; Truman S. Smith, Secretary, 145 West Wallace St., Findlay 45840. 1st Tuesday monthly.

HARDIN—Jay Pfeiffer, President, 215 Main St., Kenton 43326; John Hughes, Secretary, 601 Pattison Ave., Kenton 43326. 2nd Tuesday evening monthly.

LOGAN—Donald Wyse, President, Oakhill Medical Association, West Liberty 43357; Douglas W. Beach, Secretary, 1008 North Main St., Bellefontaine 43311. 1st Friday monthly.

MARION—John E. Aiken, President, 1040 Delaware Ave., Marion 43302; Brooks Sitterly, Secretary, McKinley Parkway Dr., Marion 43302. 1st Tuesday monthly.

MERCER—George H. McIlroy, President, 123 East Fayette St., Celina 45822; D. J. Schwieterman, Secretary, Maria Stein 45860. 3rd Thursday.

SENECA—Leroy Cummings, President, 455 W. Market St., Tiffin 44883; Donald Shanabrook, Secretary, 455 West Market St., Tiffin 44883. 3rd Tuesday evening Jan., March, May, July, Sept. and Nov.

VAN WERT—Thomas R. Wilson, President, Van Wert County Hospital, Van Wert 45891; Robert Scheidt, Secretary, Medical Arts Building, Van Wert 45891. 4th Friday.

WYANDOT—D. P. Smith, President, Pennington St., Sycamore 44882; K. K. Solacoff, Secretary, 777 North Sandusky Avenue, Upper Sandusky 43351. 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43624
316 Michigan St.

DEFIANCE—Jack A. Kane, President, Central Foundry, Defiance 43512; Miss Lois Coffin, Executive Secretary, Defiance Hospital, Defiance 43512. 1st Saturday.

FULTON—R. L. Davis, President, 137 South Fulton St., Wauseon 43567; M. S. Renfrew, Secretary, Lutz Rd., Archbold 43502. Quarterly meetings March, June, Sept. and Dec.

County Society Roster (continued)

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545.

LUCAS—Roland L. Kennedy, President, 4639 Farmington Rd., Toledo 43623; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday,

OTTAWA—Donald F. Loeffler, President, 521 East Second St., Port Clinton 43452; Gordon R. Ley, Secretary, P. O. Box J, Port Clinton 43452. 2nd Thursday evening monthly.

PAULDING—Kirkwood A. Pritchard, President, 119 South Main St., Paulding 45879; Don K. Snyder, Route #2, Paulding 45879. 3rd Monday monthly at the Paulding County Memorial Hospital.

PUTNAM—James B. Overmier, President, 109 Main St., Leipsic 45856; Arthur P. Daniel, Secretary, 144 North Walnut St., Ottawa 45875. 1st Tuesday.

SANDUSKY—Allen Schaengold, President, 325 South Park Ave., Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday except June, July, and August.

WILLIAMS—P. G. Meckstroth, President, Central Drive, Bryan 43506; S. O. Cooper, Secretary, Central Drive, Bryan 43506. 3rd Tuesday.

WOOD—William Roberts, President, North Baltimore 45872; William F. Lord, Secretary, 950 West Wooster St., Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: David Fishman, Cleveland 44106
10515 Carnegie Avenue

ASHTABULA—W. B. Millberg, President, 430 West 25th Street, Ashtabula 44004; Mrs. Donna L. Miggo, Executive Secretary, P.O. Box 1772, Ashtabula 44004. 2nd Tuesday.

CUYAHOGA—Vincent T. LaMaida, President, 4125 Mayfield Rd., Cleveland 44121; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106. Board meets 2nd Tuesday.

GEAUGA—Oscar Brinckmann, President, 12475 Hospital Dr., Chardon 44024; Mrs. Ruth Milgate, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024. 2nd Friday.

LAKE—John J. Cahill, President, 36001 Euclid Ave., Willoughby 44094; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060. 4th Wednesday of Jan., March, May, Sept. and Nov.

Sixth District

Councilor: Maurice F. Lieber, Canton 44703
515 Third St., N. W.

COLUMBIANA—John A. Fraser, President, 403 Little Building, East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460. 3rd Tuesday monthly.

MAHONING—Robert L. Jenkins, Jr., President, 21 Wickliffe Circle, Youngstown 44515; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44505. 3rd Tuesday, except June, July and August.

PORTAGE—Kenneth F. Rupp, President, 9160 State Route 43, Streetsboro 44240; Miss Marie Motyka, Executive Secretary, 430 Grant St., Akron 44311. 3rd. Tuesday.

STARK—Frank O. Goodnough, Room 615, President, Peoples-Merchants Trust Building, Massillon 44646; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday.

SUMMIT—Edwin W. Cauffield, President, 505 Ohio Building, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311 2nd Tuesday, excluding July and August.

TRUMBULL—J. R. Phillips, President, St. Joseph's Hospital, N. Tod Avenue, Warren 44485; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday, September through May.

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth St.

BELMONT—Thomas L. Ring, President, 3205 Belmont Street, Bellaire 43906; Bertha M. Joseph, Secretary 100 South 4th Street, Martins Ferry 43935. 3rd Thursday, except January, May, July and August.

CARROLL—T. J. Atchison, President, 292 East Main St., Carrollton 44615; Jack L. Maffett, Secretary, 264 South Lisbon St., Carrollton 44615. 3rd Tuesday.

COSHOCTON—Myron Saturski, President, 149 South Bridge Street, Newcomerstown 43832; Robert W. Secrest, Secretary, 1926 Melbourne Road, Coshocton 43812. 2nd Tuesday.

HARRISON—R. W. Weiser, President, Jewett 43986; Janis Trupovnieks, Secretary, Hopedale 43976. Quarterly, March, June, Sept. and Dec.

JEFFERSON—Crist G. Strovilas, President, 812 North Fourth St., Toronto 43964; Mrs. Mary Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952. 4th Tuesday, except Aug. and Dec.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—P. T. Doughten, President, 551 Wabash Ave. N. W., New Philadelphia 44663; M. R. Puterbaugh, Secretary, 104 Iron Ave., Dover 44622.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson Street

ATHENS—Dale Mattmiller, President, Hudson Health Center, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. Second Tuesday quarterly, September, December, March, and June.

FAIRFIELD—R. A. Welsh, President, Lancaster-Fairfield Hospital, Lancaster 43130; C. R. Reed, Secretary, 309 East Main Street, Lancaster 43130. 2nd Tuesday.

GUERNSEY—Merritt C. McCuskey, President, 1200 Edgeworth Ave., Cambridge 43725; Quentin F. Knauer, Secretary, 100 Clark Ct., Cambridge 43725. 1st Tuesday monthly, 7 P.M., Cambridge Country Club.

LICKING—Edward A. Carlin, President, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055; G. Franklin Gabe, Secretary, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055. 4th Tuesday monthly.

MORGAN—Asa Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 East Union Ave., McConnelsville 43756.

MUSKINGUM—James F. Morton, President, 727 Market St., Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Ave., Zanesville 43701. 1st Tuesday.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Box 239, Caldwell 43724. 1st Tuesday.

County Society Roster (continued)

PERRY—A. G. Cruz, President, 203 North Main St., New Lexington 43764; R. E. Herendeen, Jr., 203 North Main St., New Lexington 43764.

WASHINGTON—Gregory B. Krivchenia, President, 326 Third St., Marietta 45750; Donald E. Fleming, Secretary, Vincent 45784. 2nd Wednesday monthly.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—Arturo de Lamerens, President, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631; Donald M. Thaler, Secretary, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631. Quarterly meetings at call of officers.

HOCKING—Lethia W. Starr, President, 109 Mulberry St., Logan 43138; J. W. Doering, Secretary, 42 North Spring St., Logan 43138. 2nd Tuesday monthly.

JACKSON—Earl Levine, President, 120 North Ohio Avenue, Wellston 45692; John M. Cook, Secretary, Box 316, Oak Hill 45656. Meetings when called.

LAWRENCE—A. Burton Payne, President, 411 Center Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly meetings.

MEIGS—Charles J. Mullen, President, 210½ East Main St., Pomeroy 45769; E. Butrimas, Secretary, 204 East Main St., Pomeroy 45769.

PIKE—W. W. Wiltberger, President, 330 East North St., Waverly 45690; Thomas Hwang, Secretary, 300 Cherry St., Waverly 45690. 1st Tuesday monthly.

SCIOTO—Joseph T. Gohmann, President, c/o Scioto County Medical Society, 1805 27th St., Portsmouth 45662; Mr. Lowell Thompson, Executive Secretary, 1805 27th St., Portsmouth 45662. 6:30 p.m. 2nd Tuesday.

VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050
104 E. Gambier St.

DELAWARE—John L. Binkhorst, President, 26 Northwood Dr., Delaware 43015; Lloyd E. Moore, Secretary, Magnetic Springs 43036. 3rd Tuesday except June, July and Aug.

FAYETTE—H. W. Payton, President, 36 South Main Street, Jeffersonville 43163; M. H. Roszmann, Secretary, 1005 East Temple Street, Washington C. H. 43160. 2nd Friday.

FRANKLIN—Philip H. Taylor, President, 3545 Olentangy River Rd., Columbus 43214; Mr. W. "Bill" Webb, Executive Secretary, 17 South High St., Suite 528, Columbus 43215. 3rd Tuesday except June, July and Aug.

KNOX—James R. McCann, President, Medical Arts Building, Mount Vernon 43050; Robert Westerheide, Secretary, Medical Arts Building, Mount Vernon 43050. 1st Wednesday.

MADISON—Brawley Arikawa, President, 176 North Madison Road, London 43140; William T. Bacon, Secretary, 194 Elm Street, London 43140. Four times a year, 2nd Wednesday (3, 6, 9, 12).

MORROW—David James Hickson, President, 712 Baker St., Mount Gilead 43338; Lowell Murphy, Secretary, 209 South Main St., Cardington 43315. 1st Tuesday monthly.

PICKAWAY—H. H. Swope, President, 400 North Court St., Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney St., Circleville 43113. 1st Tuesday except July and Aug.

ROSS—Roy Manning, President, 1 Overlook Dr., Chillicothe 45601; Paul MacCarter, Secretary, 60 Central Center, Chillicothe 45601. 1st Thursday.

UNION—John R. Linscott, President, 225 Stockdale Dr., Marysville 43040; May B. Zaugg, Secretary, Route 5, Timber Trails, Marysville 43040. 1st Tuesday of Feb., April, Oct. and Nov.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Rd.

ASHLAND—William Emery, President, 247 Sandusky Street, Ashland 44805; J. H. Cooperrider, Secretary, 637 North Union Street, Loudonville 44842. 1st Thursday.

ERIE—R. H. Williamson, President, 410 Wasta Rd., Huron 44839; Mrs. Barbara Wolfert, Executive Secretary, 1428 Hollyrood Rd., Sandusky 44870. 2nd Tuesday except July and Aug.

HOLMES—Daniel J. Miller, President, Walnut Creek 44687; Charles H. Hart, Secretary, 109 South Clay St., Millersburg 44654. First (or Second) Thursday 7 P.M. (Sometimes it may follow hospital staff meeting.)

HURON—John E. Rosso, President, 218 Myrtle Ave, Willard 44890; Russell R. Fisher, Secretary, 257 Benedict Ave., Norwalk 44857. 2nd Wednesday of February, April, June, October and December.

LORAIN—Robert P. McFarland, President, Oberlin Clinic, Inc., 224 West Lorain Street, Oberlin 44074; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday for REGULAR MEETINGS. Last Thursday of the month for COUNCIL MEETINGS.

MEDINA—H. E. Grover, President, 146 North Lyman Street, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 943 N. Jefferson Street, Medina 44256. 3rd Thursday.

RICHLAND—Robert W. Jones, President, 120 Sturges Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, c/o Mansfield General Hospital, Mansfield 44903. 3rd Thursday except June, July and August.

WAYNE—Frank Cebul, President, 1740 Cleveland Road, Wooster 44691; Thomas Graves, Secretary, 1740 Cleveland Road, Wooster 44691. 2nd Wednesday of alternate months.

For Roster of OSMA Officers and Committeemen
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Advertisers in *The Journal* are friends of the profession. By accepting their advertising we show confidence in them and in their services and products. They underwrite a large portion of the printing cost of *The Journal*, and help make it a quality publication. In return we place their messages on the desks of Ohio's physicians. Please familiarize yourself with their services and products, and let them know that you see their advertising in *The Journal*.

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Box (insert number), c/o The Ohio State Medical Journal
17 South High Street, Suite 500, Columbus, Ohio 43215

Physicians seeking locations in Ohio are invited to contact the Physicians' Placement Service in the executive offices of the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215. Through this medium efforts are made to establish communications between physicians seeking locations and communities where physicians are needed, or other physicians who are in need of associates.

EXCELLENT OPPORTUNITY: Large industrial private medical practice, Southwestern Ohio, wishes associate. Reply Box 547, c/o Ohio State Medical Journal.

IMMEDIATE OPENING: INTERNIST or General Practitioner to join six man multi-specialty group in northeastern Wisconsin. Excellent professional opportunity to practice in a friendly community, only two actively practicing physicians (General Practitioners) in the community outside of our clinic. Salary commensurate with training and experience first year and then full partnership. Ideal, safe small city living for the family on scenic Lake Michigan with excellent fishing, boating and hunting. All this and still only 1½ hours drive to Milwaukee or 45 minutes to Green Bay or lovely Door County. For complete details contact Robert E. Myers, M.D., Garfield at 23rd., Two Rivers, Wisconsin 54241.

GENERAL PRACTITIONER OR INTERNIST— Available immediately. Busy practice for G.P. or Internist desiring family practice without Obstetrics. Group consists of 3 G.P.'s and Surgeon, in new building with lab and x-ray facilities. Local 50 bed J.C.A.H. approved hospital. Rural area with excellent school system. Ready access to Cleveland, Akron, Columbus. No investment. Early partnership. Housing available. Reply John A. Grafton, Business Mgr., Lodi Medical Building, 402 Highland Dr., Lodi, Ohio 44254 or phone (216) 948-1555.

UNIVERSITY STUDENT HEALTH PHYSICIANS: Two immediate openings, Northwest Ohio, 13,000 students, modern new facilities, 102 bed hospital and complete lab. & x-ray facilities; excellent salary, fringe benefits, vacation, and working conditions. Reply Box 590, c/o The Ohio State Medical Journal.

PSYCHIATRIC RESIDENCY — modern 120 bed hospital in Akron suburb, 40 mins. from Cleveland; comprehensive 3 yr. approved program. Area growing; high demand for psychiatrists. M. Menassa, MD., DME, Fallsview Mental Health Center, Cuyahoga Falls, Ohio 44222 (216) 929-8301.

RESIDENCY P.M. & R.: Newly approved Physical Medicine & Rehabilitation residency in 1500 bed University of Cincinnati Medical Center. Training includes P.M. & R. bed service, clinics, consultations, and EMG under four full-time physiatrists. Emphasis on comprehensive patient care. Individual training programs may start at anytime. For further information contact: Robert H. Jebsen, M.D., Professor & Director, Department of Physical Medicine & Rehabilitation, University of Cincinnati Medical Center, Cincinnati General Hospital, 234 Goodman Street, S2-15, Cincinnati, Ohio 45229.

RETIRED RADIOLOGIST has building equipment for sale. Located at 328 E. State St., Columbus, Ohio across from Grant Hospital. Suitable for Radiologist, Internist or Orthopedist. Contact Dr. W. H. Miller, 328 E. State St., Columbus (614) 221-3743.

OPENING SOON!

Announcing second new professional building opening. Prime location at Route 161 and Tamarack Blvd., Columbus, Ohio. Excellent for General Practitioner, Internist or other specialists. Contact: Metzger Management Company, 1901 E. Dublin-Granville Rd. (Route 161), Columbus, 43229 or call (614) 885-9800.

INTERNISTS AND PEDIATRICIANS: Openings with multi-specialty group of seven physicians seeking future partners in area serving N. Ridgeville and Elyria, Ohio (combined population of 75,000). Excellent opportunity to practice in a friendly fast growing community. High starting salary with liberal fringe benefits. Call Elyria (216) 365-7311 or write Edwin G. Haywood, Administrator, Center Ridge Clinic, Inc., 39000 Center Ridge Rd., North Ridgeville, 44035.

— More Classified Ads on Next Page —

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(Continued from Previous Page)

PHYSICIAN'S OFFICE FOR RENT in Mariemont, a Village adjacent to Cincinnati, near a good hospital. Contact L. Hermanies, 3900 Oak St., Mariemont, Ohio, Phone 271-0291.

CANTON, OHIO—Medical Office adjacent to New Belden Village Shopping Center and Lake Cable area. Prime office space with reasonable rent. Inquire: Ernest Pagonis, D.D.S., 5208 Fulton Dr. N.W., Canton, Ohio 44718. Telephone 499-7881.

CENTRALLY AIR CONDITIONED FULL SERVICE OFFICE: Prime University Heights, Cleveland Heights, South Euclid intersection. Excellent for Internist, General Practitioner, Ophthalamologist, or other specialist. Opposite May's on the Heights. Doctors Center Bldg. 14077 Cedar Road, Cleveland, Ohio 44118. Phone 216-321-5060.

INTERNIST AND PEDIATRICIAN WANTED — Group of two general surgeons and one obstetrician-gynecologist looking for board qualified or certified internist and pediatrician. We are creating a partnership of young well trained physicians in a mutual complimentary practice. Incorporation is in process with excellent fringe benefits. We are located in north central Wisconsin serving a community of approximately 25,000 with a summer population of 200,000. We have excellent recreational and educational facilities including college. Starting salary is $25,000 wth partnership after one year. Anyone interested write to Dr. I. E. Schiek Jr. c/o The Schiek Clinic, Rhinelander, Wisconsin 54501 or call collect 715-362-6160.

EMERGENCY ROOM PHYSICIAN WANTED to complete group. 40 hour week. No private practice allowed. $25,000 annual guaranteed plus percentage. Present group operating successfully. Accredited hospitals with opportunity to assist major surgery for additional remuneration. A southern Ohio city. Ohio license required. Call collect either J. T. Gohmann, M.D., or M. J. Daus, M.D. 614-354-5315.

PSYCHIATRIST —To direct M.H. Clinic in city of 35,000 in N.W. Ohio. Staff includes Ph.D. and M.S.W. Salary range $25,000 + liberal fringes. Contact W. B. Elderbrock, M.D., 111½ W. Pearl, Findlay, Ohio 45840.

NORTHFIELD, OHIO — Physicians who are state licensed or holding ECFMG, required for institutional practice in a hospital located near Cleveland, Ohio. Living quarters and other benefits available. Write or call Eliere J. Tolan, M.D., Superintendent, Hawthornden State Hospital, Box 305, Northfield, Ohio, 44067 or call A.C. 216-467-7131.

INTERNIST board certified or eligible sought by 30 man multispecialty group in southeastern Ohio. Outstanding professional opportunity in modern medical facilities, located in pleasant, safe community. High salary first year, then partnership. Call or write Oscar W. Clarke, M.D., AC 614 446-1332, or Charles E. Holzer, Jr., M.D., AC 614 446-2244, The Holzer Medical Center Clinic, Gallipolis, Ohio, 45631.

ELECTRIC STAIRWAY FOR SALE: Slightly used, single seat "Inclinator," suitable for invalids. Contact R. L. Mansell M.D., 212 S. Broadway, Medina, Ohio 44256, Tel. 723-7591.

STAFF PHYSICIAN — Full-time staff physician needed for Intermediate Service 732 bed general medical and surgical hospital. Ohio State University Medical College affiliated. Faculty members conduct conferences, clinics, and participate in a diversified residency training program. Medical license in any state acceptable; salary range $19,643 to $25,937 per annum depending upon qualifications. Moving expenses paid. Maximum leave and insurance benefits; noncitizens will be considered; nondiscrimination in employment. Write: Center Director, Veterans Administration Center, 4100 West Third Street, Dayton, Ohio 45428.

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GENERAL PRACTITIONER sought by 30-man multispecialty group in southeastern Ohio. Outstanding professional opportunity in modern medical facilities, located in pleasant, safe community. High salary first year, then partnership. Call or write Oscar W. Clarke, M.D., AC 614 446-1332, or Charles E. Holzer, Jr., M.D., AC 614 446-2244, The Holzer Medical Center Clinic, Gallipolis, Ohio 45631.

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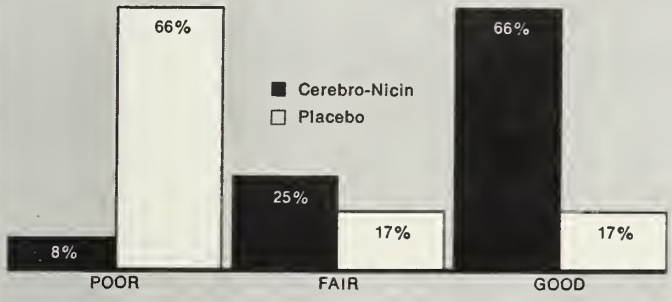
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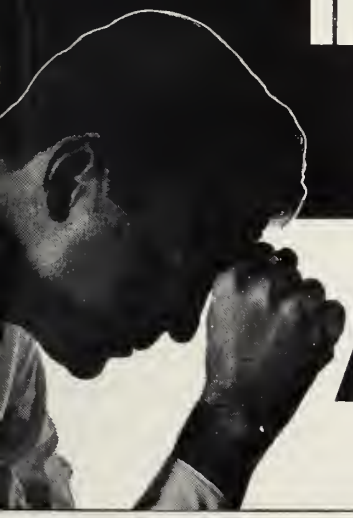
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References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Oublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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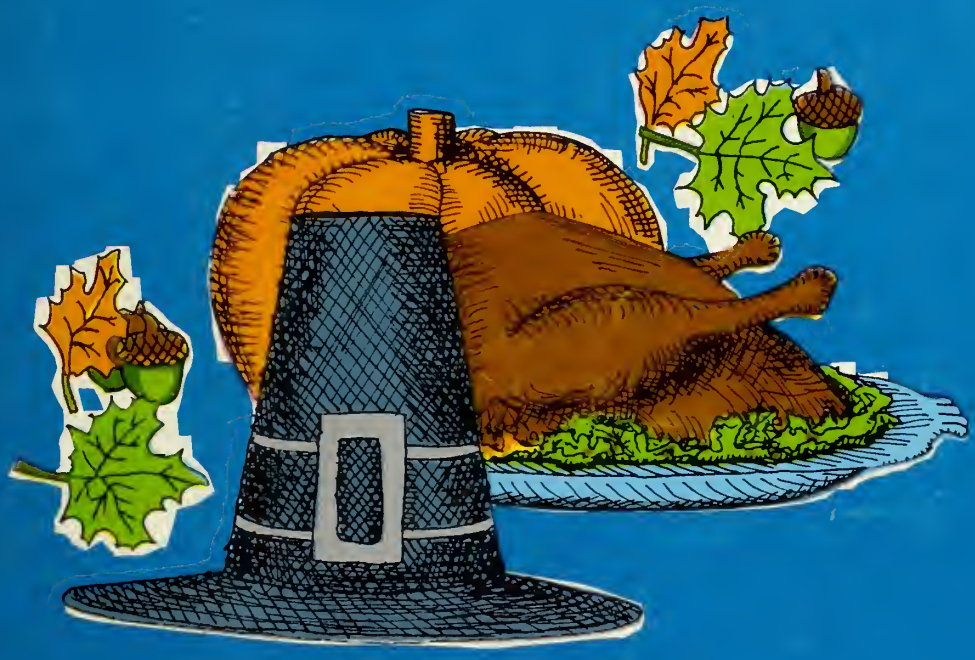
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NOVEMBER 1970
Vol. 66 • No. 11

The Ohio State MEDICAL JOURNAL

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION



America's Heritage

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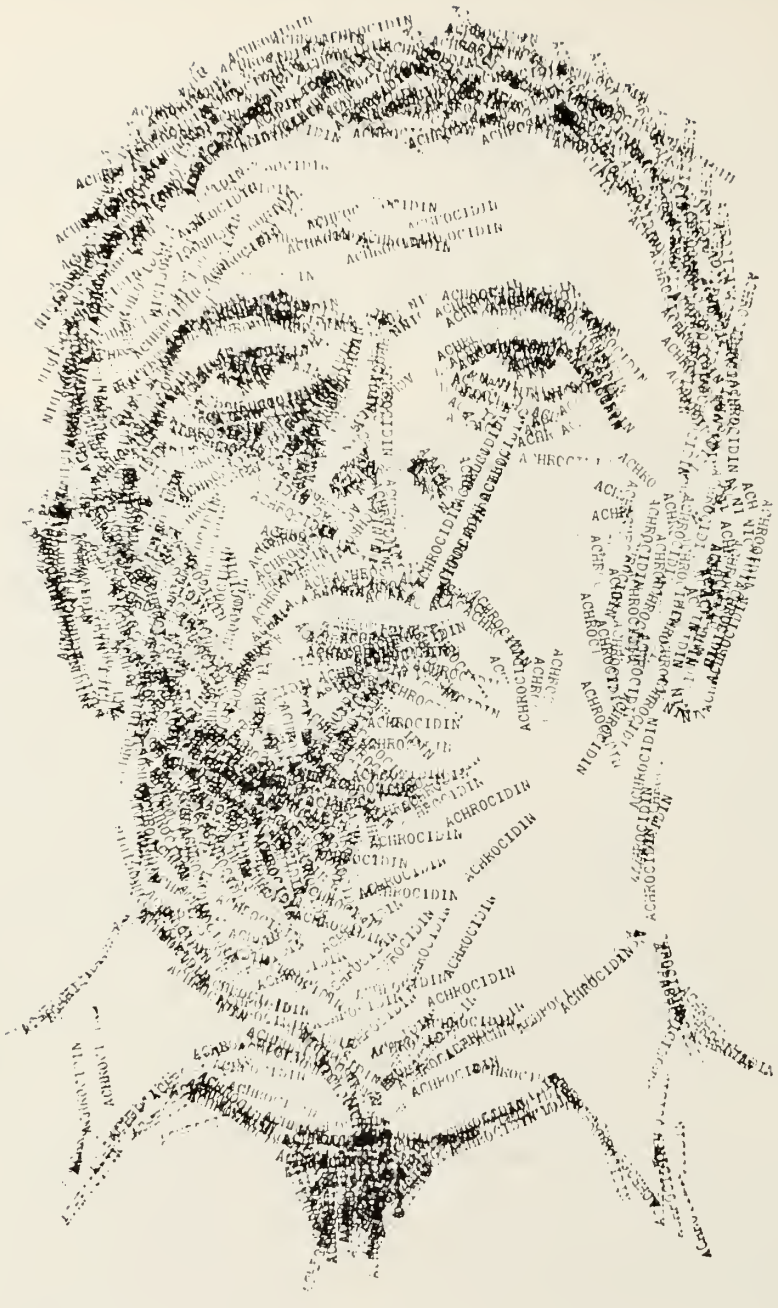
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(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

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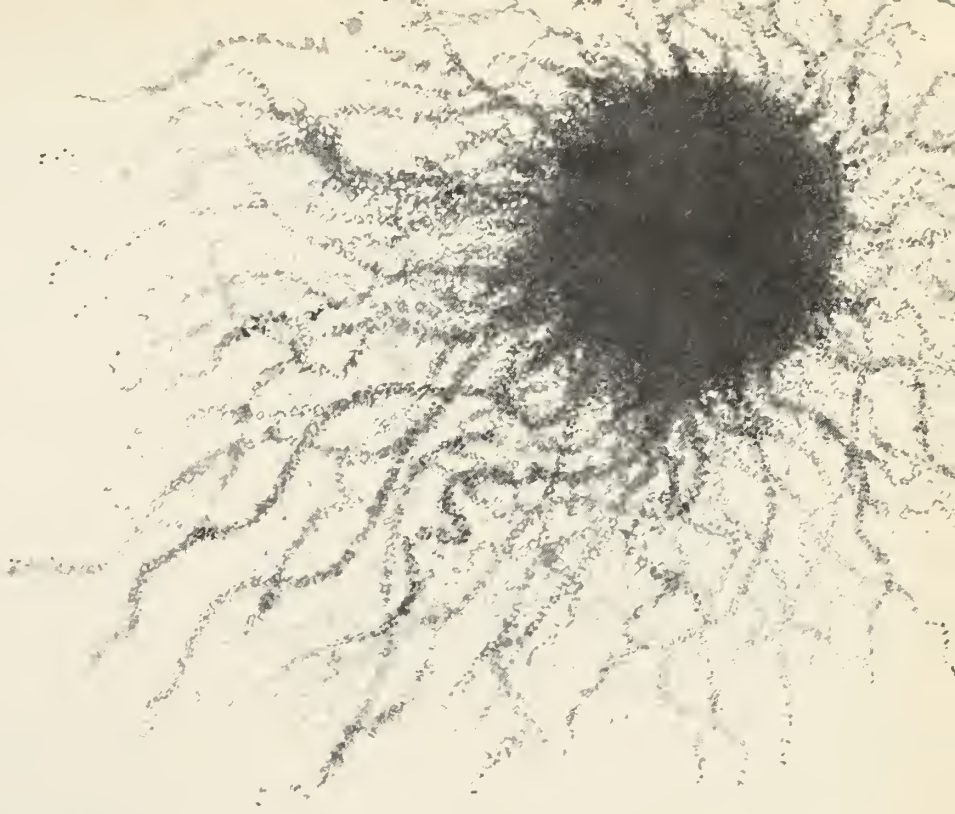
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Public Health in Ohio

ODH Director Reviews Pollution Control as One of Many Projects in the Total Health Picture for the State

By Emmett W. Arnold, M.D.
Director, Ohio Department of Health

WELCOME TO THE Annual Conference of Ohio Health Commissioners with the Ohio Department of Health. This is our 51st conference, although it hardly seems possible that one whole year has passed since our 50th conference.

Pollution Control

On the other hand, although time has passed quickly, we have had enough activities scheduled during the past 12 months to fill three calendar years. Just to give you an idea, the Ohio Water Pollution Control Board conducted 128 enforcement hearings. That's more hearings than the Board conducted during the first eight years of its existence.

In addition to that, we have conducted or participated in public hearings on air or water pollution in Cincinnati, Cleveland, Toledo, Ironton, Youngstown, Steubenville, Dayton, and Columbus. We have established a board for licensing nursing home administrators and a board for hearing aid dealers, and begun a statewide fluoridation program. These activities have been in addition to regular preventive disease programs.

The pressure of this increased tempo of activity is intensified by urgent demands from all levels. We are living in an impatient era, an era when everyone is demanding and expecting instant health. No longer does nature get a chance to heal the body over a period of time. At the first symptoms, the self-diagnoser starts the pills.

We see this impatience with suddenly perceived ills of our physical environment. The instant cure is proposed, recommended. and demanded. Usually the cure proposed is superficially determined as is the cure for the cold, allergy, ache, or pain.

This article is based on a report presented before the annual Conference of Ohio Health Commissioners with the Ohio Department of Health, Columbus, September 9, 1970, and a report presented by Dr. Arnold before The Council of the Ohio State Medical Association on September 19, 1970.

Total Environment Concept

There is an increasing awareness of the total environment and the total health of people. Fantastic strides have been made in guidelines and methodology for curing and even preventing health handicaps. We in Ohio can take pride in our progress, but we can't rest on our laurels for our efforts still fall far short of controlling either environment or health.

At a time when pollution has suddenly become the source of concern and worry to many and the source of political and research plums for others, the public should be relying on public health authorities for counsel. However, there really is no unanimity among the health authorities and the conflicting opinions offered with gusto command no public respect for the field. Without discussing possible motivations or constraints which individuals might justify, let me point out that our efforts to fully identify cause and effect under this cloud of hysteria leave much to be desired.

For example, health in Ohio ranks among the top in the nation. And Ohio has a variety of influences on the environment—both natural and manmade—which also ranks among the top states in the country. Ohio has ongoing programs for the abatement of air and water pollution which are second to none. And yet we read of criticism by persons in distant cities who, ignorant of the facts, make assertions which suggest Ohio is not doing a job in protecting the environment. The inference is that health in Ohio is jeopardized. No facts; just an accusation.

Opinions vs Scientific Fact

But by the same token, we lack data to show that the health in the so-called polluted areas is not comparable to the cleaner areas. We also lack data to show whether eating habits, living conditions, mental attitudes, or working schedules are causal factors in variation around the state. We have opinions, but we lack data on the total environmental effects on man.

Or consider this example: The controlled ingestion of fluoride has been demonstrated to mini-

mize dental caries. This fact is supported by all nationally recognized health authorities and yet it is not universally accepted by the public. Less well known are studies which indicate traces of vanadium in water supplies are correlated with a 50 percent reduction in coronary deaths as compared to states which do not have this trace element. Of greater importance is the reported lack of a statistically significant difference between urban and rural residents in coronary rates if vanadium is absent. This is one of the factors not fully assessed in the proposed carbon monoxide standards which uses the coronary rate as a control.

Similarly, traces of selenium appear to reduce arteriosclerosis and endemic anemia flourishes with a deficiency of iron.

These illustrations serve to emphasize the necessity to consider all factors of the environment—air, water, food and the social as well as mental stimuli which can affect a study proposing causal relations.

Is Absolute Purity Our Goal?

With our present kick on purity—or rather a kick against pollution—the assumption is easily justified that impurities are bad. We made that mistake a number of years ago when the demand was for pure flour. You recall we finally got a pure flour but it had one drawback—it was useless. Now we add the impurities which had been removed and call it fortified or enriched flour.

Pollution control activities have taken much of our time during the past 12 months. In addition to our routine schedule, we participated in the Lake Erie hearings conducted by the Federal Water Quality Administration last October; we conducted public hearings on the water quality standards for the Muskingum River Basin and the Mahoning River, Little David Creek, Pymatuning Creek, and Yankee Creek; and the Board went to Cleveland last April for a close look at that city's problems.

The Ohio Water Development Authority is now in operation and doing business. One hundred and forty-seven projects costing $336,000,000 have been approved for Fiscal 1971 and will be eligible for grants.

Our air pollution control program, which is another reason we've been so busy, is now in high gear. The Air Pollution Control Board has held public hearings in Cincinnati, Cleveland, Ironton, Steubenville, and Dayton. We have already adopted air quality standards for Cincinnati, Cleveland, and Ironton, and we will adopt standards for the other two regions within the next few days.

The solid waste program has been progressing satisfactorily, thanks to the cooperation of health commissioners, but we will have a long way to go before we can relax our efforts. In fact, all environmental problems are coming at us so fast, we have to run to stand still.

Preventive Measures

As for the remainder of this annual report, most of the news is good news. The rheumatic fever death rate in Ohio has declined to the lowest level in history. It's hard to believe that 20 years ago eight times as many persons died from acute rheumatic fever as in 1969.

The rheumatic fever registeries operating in local health departments are one reason for the decline in the death rate. Approximately 40,900 persons were registered as of the 1st of July. The Department sends from 500 to 1700 drug orders for the prevention of rheumatic fever to your offices weekly.

Fifty-six counties have organized mail-in strep throat culture service for physicians. The public is encouraged to seek medical care for sore throats, and drug prophylaxis for secondary attacks should be continued indefinitely.

We have been warning the public about the dangers of cigarette smoking, and this may be one of the reasons for a decline in tobacco sales. Ohio smokers purchased 46 million fewer packs of cigarettes in Fiscal 1970 than they did in Fiscal 1969. The elimination of cigarette advertising on radio and television after January 2, 1971, may help reduce cigarette smoking.

The death rate for cervical cancer continues to decline, probably due to the increasing use of the cervical cytological examination followed by appropriate treatment. Emphasis on availability of cervical cancer detection services should be increased, particularly for the poor.

There continues to be a gradual increase in the occurrence of death from breast cancer. Public recognition of the problem, professional acceptance of breast examination as an important part of a physical examination, and improved methods of early detection all need emphasis.

We are making progress in identifying diabetes. Fourteen counties and two cities have organized diabetes community screening services. In screening programs involving 26,000 persons, 246 unsuspecting individuals learned that they were diabetics.

Some Problem Areas

Food-borne disease remains a problem in Ohio. A large outbreak occurred in a state hospital in July when approximately 120 persons became ill. *Bacillus cereus* was suspected as the eti-

ologic agent. A number of *Salmonellosis* have been reported. One severe case occurred in a child who developed a brain abscess. *Salmonella* organisms of the same type were found in a pet turtle in the home.

Gonorrhea continued to spread in Ohio with 25,000 cases in Fiscal 1970 as compared to 20,000 in 1969. Projects are being started in Lima and Columbus to attempt further study of the problem, particularly infections in females. A physician has been assigned by the Public Health Service to the Columbus City Health Department to implement this program.

Syphilis incidence is down to 3,900 cases from 4,900 last year. We believe that the concentrated epidemiologic effort has contributed to this improvement.

Serum Hepatitis is increasing in evidence, particularly in drug users. Forty-three cases have occurred in drug addicts as compared to only 28 associated with blood or blood products.

Malaria is being reported with more frequency. We had 71 cases last year, mostly servicemen from Vietnam. We are maintaining constant surveillance to prevent establishment of malaria in Ohio.

In May of 1970 our attention was called to an outbreak of illness in Willis Junior High School in Delaware. Over 300 students and faculty were ill out of a total of 950. Laboratory tests confirmed a diagnosis of histoplasmosis. The acute nature of the outbreak indicated a probable single exposure airborne infection. Investigation indicated that clean-up activities which took place around the building on April 22, 24 and 25 probably resulted in heavy contamination of the air with dust. Culture of soil samples is underway and appropriate corrective measures will be recommended to prevent recurrences. Fortunately, there were no deaths or serious illnesses resulting from this outbreak.

Encouraging Progress

Rubella vaccinations are continuing in a concentrated effort to prevent further measles epidemics. Approximately one million children have been immunized, chiefly through school programs, and an additional 1.5 million in the 1 to 10 age group remain to be vaccinated.

Newly reported active tuberculosis cases declined from 1,375 in 1968 to 1,363 in 1969. Ac-

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cording to the Tuberculosis Morbidity and Mortality Report, deaths due to tuberculosis were 248 in 1968 and 254 in 1969. The number of patients hospitalized in tuberculosis hospitals declined 16 percent from 807 in July of 1969 to 654 in July of 1970.

We are making progress in maternal health services. There are now projects in Dayton, Cincinnati, and Springfield providing care and habilitative services for unwed mothers. We have workshops around the state to prepare instructors of classes in preparation for parenthood. Thirteen counties now have prenatal clinic services.

The greatest expansion in the maternal health area came in the development of family planning. As of now 60,000 women in 44 counties are receiving care. During the past year in cooperation with the Ohio Planned Parenthood Association we have provided consultation and aid in grant development to 33 additional counties.

The pediatric otologic diagnostic centers provided services to 2,619 children in 71 counties—an increase of 9 percent over last year. A new program was started in Stark County, and negotiations are underway to develop other centers in the northeast part of the state.

Expanded Facilities

The Department has continued to work with universities and communities to provide speech therapy services. Seven new part time centers were established last year bringing the total to 25 counties with six full time community speech centers. In many cases these projects have been receiving increasing financial support locally.

Diagnostic centers for visual disorders are also being developed. Four clinics were conducted on a trial basis last year and we should have several new centers in the near future.

Our new laboratory building, which has been under construction since July of 1969, will be completed early in 1971. This will enable laboratory staff presently in four locations in Columbus to become consolidated in the one building.

The laboratory was a participant for evaluations from the National Communicable Disease Center in syphilis serology and various phases of microbiology and other serology. There was also a special hemoglobin study, three complete phases of the Cooperative Glucose Standardization Program, oxygen demand samples for the Analytical Reference Service, and split milk samples for bacteriological tests.

A wide variety of chemical determinations were under the broad heading of occupational health, air pollution, radiological health, pesticides, and biochemistry.

Data from air samples from the Greater Cincinnati Air Quality Control Region were used to establish the proposed standards for sulfur dioxide and suspended particulate matter.

A new activity is the pesticide residue analysis of foodstuffs and agricultural products collected by sanitarians. Residues of one or more common pesticides were found in the very low parts per million concentrations in some samples.

Microbiology examinations again increased in number, the greatest increase being for streptococcus cultures and Group A fluorescent determinations, 23 percent; parasite examinations, 22 percent; bacterial and mucotic cultures for identification, 17 percent and gonorrhea smears, 10 percent. The increase in miscellaneous bacterial culture reflects an increasing proficiency and interest in bacteriology in local laboratories.

The following numbers of tests, examinations, and analyses should give you some idea of the volume of work handled by our laboratories: Microbiology, 202,264; Serology, 138,671; Virology, 26,554; Phenylketonuria, 177,178; Sanitary Chemistry, 67,233; Industrial Chemistry, 73,112.

With regard to dental activities, reports received by the Department indicate that school health and education program activities conducted by local health agencies throughout the state resulted in screening dental examinations of 249,000 school age children.

Clinical Projects

Members of our staff conducted a comprehensive dental health program in which 19,304 students in 93 elementary schools participated. In addition to group instruction on oral hygiene and preventive dentistry, 4,149 children were given a dental examination, an oral prophylaxis, a toothbrush, and a topical application of accidulated fluoride phosphate.

We estimate that by the end of this year 83.2 percent of the state's population served by water supply systems will be drinking water containing an optimum amount of fluoride. This percentage will be increased to 88.9 percent by the end of 1971 at which time an estimated 6,866,239 persons will be receiving the health benefits of fluoride from water sources.

In comparing the projected fluoridation status of Ohio with projected data from other states, it would appear that Ohio may attain the distinction of ranking fourth among all states with regard to the number of persons using fluoride sufficient drinking water.

While it can be assumed that Ohio's fluoridation law will eventually and substantially reduce the incidence level of dental caries for millions of people in the state, there will continue to be more than three million persons residing in areas where

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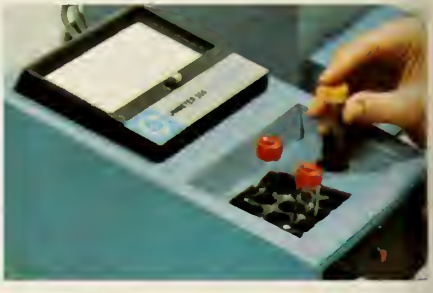
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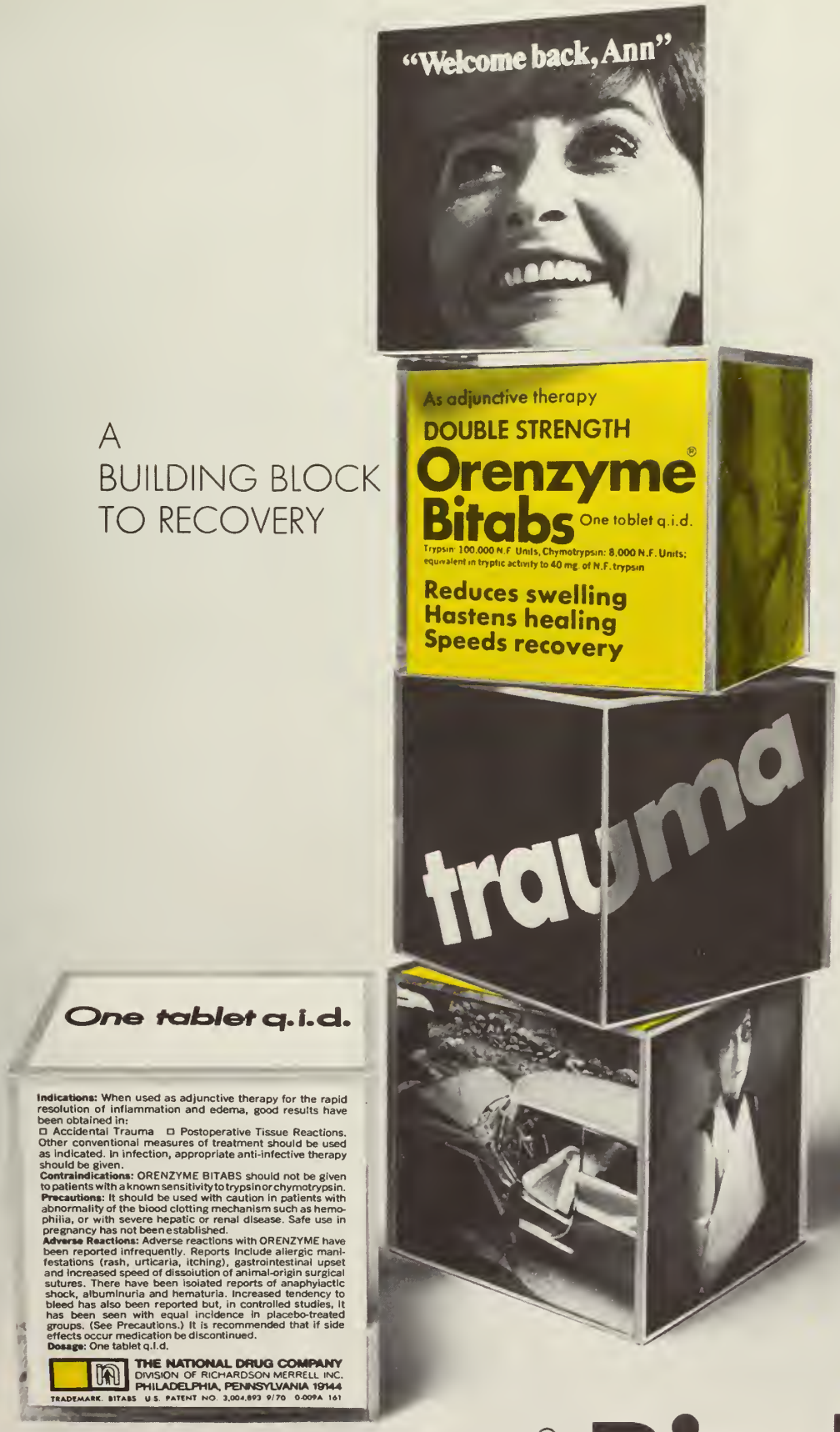
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optimum fluoride levels will not be achieved within the next few years. In this group will be thousands of children who should be provided some form of early fluoride benefits. The Department will use most of its resources and dental personnel to conduct as many topical application fluoride programs as possible for elementary school children in this category.

Our alcoholism program continues to focus on education as a technique for both preventing alcoholism and assisting in early case-finding. From the 14 community centers which make monthly service reports to us, we note a total of 4,549 interviews or counseling sessions with problem drinkers or members of their families. This total exceeds by more than 1,000 the number of interviews tallied the previous year.

We're pleased to report that Ohio now has 28 community alcoholism centers with three additional communities "standing in the wings" awaiting the availability of funds to initiate their programs. At the time of our last meeting the number of functioning alcoholism programs in the state was only 23.

Ancillary Personnel

In the field of nursing the growing demands for health services and the advances in medical sciences have greatly increased nursing responsibility. To keep the nurse practitioner current with changes in profession we sponsored training programs varying in length from one day to two weeks. Four hundred and forty-six nurses have participated in 19 training programs.

The biennial census of full time nursing personnel in public health revealed that the 394 reporting agencies employed 1,581 registered nurses, 112 licensed practical nurses, and 92 home health aides. The number of licensed practical nurses has increased from 48 in 1966 to 112 in 1970. This is due to the development and expansion of nursing care for the sick at home services and reflects utilization of different levels of nursing personnel.

In our nutrition program we have concentrated on enhancing the skills of food service personnel in nursing homes and small hospitals. The work of this group comprises an integral part of institutional health care, yet, generally, their training is minimal and very few educational opportunities are made available to them. We conducted 89 classes on principles of food service and dietary management for 389 individuals. Ninety nursing homes and 15 hospitals were represented. Also, staff members made more than 140 visits to nursing homes to provide technical guidance.

I would like to point out that the first migrant health project in this state was initiated in 1963. Since that time the number of migratory workers receiving health services has greatly increased. During 1969 our records show that 6,865 workers and members of their families made 14,168 visits to family health service clinics, private physicians offices, and to hospital ambulatory medical services. The increase over the preceding year is 27 percent in the number of individuals receiving medical care and 37 percent in the number of visits for such care.

We are doing well in administering the Emergency Medical Service Highway Safety Program. To date we have received 37 applications for financial assistance and 17 have been approved for ambulances and communications equipment costing in excess of a quarter of a million dollars.

Trends Toward Merger

We are witnessing the beginning of a new trend in Ohio with the merger of the health departments of Dayton, Montgomery County and suburban cities. This is the first major merging of large health districts since legislation authorizing such mergers was enacted in 1919.

Mergers of departments is one way for health departments to attain sufficient size to function effectively. During the past 25 years 86 communities have attained city status and all but one have merged with general health districts.

When the 1970 Census figures are released we should have more than 20 new cities in Ohio. For the long term development of strong county health departments it is imperative that contracts be negotiated with these new city administrations to merge them with the general health districts.

During the fiscal year ending June 30, 1970, expenditures for general operational costs including drugs distributed to local agencies totaled $7,852,631. Of this total, 47 percent was derived from state funds, and the balance came from federal categorical appropriations.

State funds in the amount of $903,937 were expended in the operation of the tuberculosis hospitals and to support various projects at the state level. An additional $697,327 in specialized federal categorical funds were distributed to unofficial health agencies to provide financial assistance in conducting public health projects.

Local health departments, both city and county, expended $25,208,571 during fiscal 1970. Included in this amount was $893,706 distributed by the Ohio Department of Health from federal grants to local health departments to support service and demonstration projects. Also included in the total amount expended for city and general health districts for fiscal 1970 was $420,000 from the state subsidy appropriation.

As in past years, the Department will publish and distribute a 1970 financial report of local health departments early in 1971.

The Growth and Development of the American National Health System

By James E. McGillicuddy, M.D.*

"People and governments have never learned anything from history or acted on the principles deduced from it" Wilhelm Hegel.

THE TIME IS NOW. It is imperative that we take stock of the steady progressive growth of government in our increasingly complex society. The world is reverberating with the tremors of social change. Everywhere political volcanoes are burying the old order with or without its consent, and so it is with medicine. This is happening not only in countries far advanced in socialization such as England[1] and Australia[2] but also Canada[3] which is still feeling the growing pains of a process that apparently is not completely ego syntonic. This paper, then, examines the harbingers of one of these plans, the English National Health Service, in the hope that in comparison with our own situation it may help to prevent an "it-can't-happen-here" attitude on the part of the American physician.

On the Scene Observations

Living and studying for six months at the London Hospital in England, gave me first hand experience with a force fed medical care plan, void, at its inception, of the voice or influence of the physician. The particular drawbacks of such a system are well documented by Robson[4] and are important, for they show clearly that being a medical doctor in no way guarantees control of governmental medicine. It is the author's belief that the unfortunate position of the British physician is well known but not the close resemblance between the development of their system and that in America.

The British government entered the health field in 1911, twenty-four years prior to the passage of our Social Security Act. The passage of the bill was due largely to a political magnate, Lloyd George, and was passed over unbelievable odds. It was known as the National Health Insurance Act, containing a comprehensive voluntary insurance program to aid the poor, and carrying the stipulation that enrollees be wage earners. The particulars of the plan are not important to our situation nor to the obvious parallel that exists between Lloyd George and forces at work today. What is more important for us to mark is that it was a beginning. The British physician was losing, however imperceptible, his economic freedom. History tells us as economic freedom becomes more and more exceptional, political freedom becomes a consolatory pretense.[5]

After World War I a relative prosperity existed in England, and the heralds of what were to come were barely heard and hardly noticed. They were there none the less. In 1918 the Dawson Report called for the socialization of medical practice and a radical system of health centers.[6] Tucked away, as it was in the *British Medical Journal,* it is not surprising that little notice was taken by the British doctor. What was felt acutely by the profession was the witnessing of a slow attrition of the unimpeachable esteem they had enjoyed for centuries. Some examples of this attrition can be found in Charles Dickens' *Martin Chuzzelwit,* G. B. Shaw's *The Doctors Dilemma,* and J. Austin's *The Adventures of Philip.* That the American physician is experiencing the same phenomena is obvious to us all. Probably the report that carried the greatest impact for the British doctor was the 1942 Beveridge Report[7] to Parliament. It was not unlike President Truman's Wagner-Murray-Dingell Report[8] to Congress in 1945 in its scope and content. The Beveridge Report catalyzed the actual drafting of a complicated medical care act by the coalition government under Churchill that was finally to take root four years later.

Whispers Amid Turmoil

The war, the bombs, and geography were to shorten the fuse on the British political scene. Wars, even little ones far from home, are wont to do that. So, with confusion and devastation facing them, the English people turned to the heretofore politically weak Labor Party under Clement Attlee who considered his election a mandate. Mr. Attlee appointed Aneurin Bevin Minister of Health and charged him with the politically unattractive job of assuring the passage and success of a bill conceived without the help of the medical profession. It soon became obvious

*The author is a graduate of the University of Michigan Medical School, 1965, and is currently resident surgeon, University of Cincinnati College of Medicine.

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to everyone that the bill would pass. By the time the medical association scrambled into action and appeared in Mr. Bevin's outer office, it was too late. Mr. Bevin graciously refused to discuss it.[9] [10] The physicians turned to their journals to warn against the evils of socialization in the medical care community.[11] The British Medical Association then agreed to collaborate and offer their suggestions as to changes for the good of all, but to no avail. The bill passed as drafted.

The English Health Service is now history, but the American version is still future. The lesson is for us to glean. When a government decides it is politically expedient to give its people a socialized medical care program, no obstructionistic attitudes on the part of the medical profession will prevent such a program. On the contrary, such a course of action can only result in the development of a scheme designed without the medical professional and will in all probability be unsatisfactory to him.

Steering Wheel Strategy

Let us move not for the brake, but for the steering wheel with which we have at least a chance to direct the course of our history. We still have the time at this writing, but how far we are from the siblings of H.R. 5710, Medicare-Medicaid, no one can say.

Synopsis

By examining the British National Health Service, we can learn an important lesson. The National Health Insurance Act was England's first herald, the Social Security Act was America's; both were a beginning. British physicians had other harbingers; the Dawson Report, slow attrition of the prestige of the physician, and finally the Beveridge Report. The American physicians have had President Truman's Wagner-Murray-Dingell Report. When the National Health Service Bill was assured of passage, the British Physician had lost the opportunity to have a voice in its final form. We in America have not lost that opportunity yet.

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What Goes Up Must Come Down, ... or ... Dirty Air

AIR POLLUTION must be a major health factor because everyone is so mad about it. The politicians, the women's clubs, the "conservation" groups, and college students have elevated the status of environmental pollution to the dizzy heights of the hula-hoop craze. Unfortunately, the seriousness of air pollution deserves not just verbal flux and slogans at the spinal reflex level, but constructive thought and action based on factual information.

It is disheartening to attend an antipollution meeting and find that some of the most vociferous crusaders are chain smokers who would probably be bewildered if accused of being a major source of air pollution. Yet, few gaseous industrial effluents can match these "romantic" conditions under which as much as 50 milligrams of solid wastes can be inhaled in a ten-minute period and the level of carbon monoxide in the smoke is 400 parts per million or about 20 times higher than an average industrial condition.

Bad, Worse, Worst

In debates and preventive planning it is well to separate the evils of air pollution into groups, since a bad odor may not necessarily cause disease. Thus, one might consider different levels of antisocial consequences: (1) Esthetic effects such as haze and smog, and odors, (2) personal annoyance and nuisance such as dirt and eye irritation, and (3) aggravation of existing pathology and the cause of neodiseases.

The economic losses from air pollution such as damaged clothes, rubber products, and painted surfaces and injury to plants and trees are not the primary target of public health actions, but cannot be separated from them. This is fortunate since tangible damage of material things can be estimated by a recognizable value scale (seven billion dollars a year), but it is difficult to "price" the inability to see the distant scenery or even the neighbor's picture window.

The adverse effect of air pollution on the general health has been based on several severe episodes of community-wide pollution and specific exposures under industrial conditions, but practically no valid epidemiologic studies and little experimental data are available. Man is such a resilient animal that he can survive prolonged exposure to huge amounts of coal dust and industrial vapors, and in many instances a combination of factors are required before discernible pathology develops.

Pinning Down the Problem

We need more exact studies of people exposed to high levels of pollution in order to learn



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how to detect minimal alterations of tissues that may reflect the adverse effects of ordinary pollution levels. For example, more studies are needed of traffic directors in tunnels, automechanics, roofers, millers, wood workers, coke plant operators, and such other occupations that reflect major kinds of air pollution.

Noxious odors are socially undesirable but it is difficult to prove, or even indirectly implicate them as health hazards. Downwind living by a rendering plant, a glue factory, or even a dairy may cause psychic trauma and adverse social reactions but still we have little data on the health of the "inside man at the skunk works." Is olfactory sensitivity permanently and selectively damaged as is the ear by noise pollution?

Valid epidemiologic studies are difficult to plan and complete because workers exposed to noxious odors have high turnover rates. Similarly, most people living in areas of high air pollution do not stay long and thus the detection and meaningful pathology is difficult. Further, the inhabitants of such areas are also apt to have many social and health problems that make evaluation of the contributory effects of air pollution very complex. Some so-called epidemiologic reports of the effects of air pollution on health in urban areas are unqualified nonsense.

Air pollution studies have never formed a popular area of medical research since they require long-term experiments and are obtained with the appellation of practical research.

Hopefully, health departments will assume a major responsibility for such research activities. Until valid data become available, the rule of "reasonableness"—clean air is better than dirty air—must guide our responses to this threat to our environment.

Reasonable Suggestions

The following reasonable suggestions may be helpful.

1. Develop practical legislative restrictions on all kinds of air pollution. Selective regulations cannot be avoided, but every year the rules should be restudied and the limitations tightened as new technology is developed. Legislation, surveillance, and enforcement must not be limited by city and county lines.

2. Continue to document all kinds of air pollution which cause minor complaints because of their effect on the exposed skin, the eyes, and the upper respiratory tract. Perhaps such instances should be reportable.

3. Record specific adjuvant effects of pollution on existing diseases.

4. Collect as much information as possible about lethal doses of single and multiple products,

exposures of gaseous products which are known to cause pathologic changes after (*a*) acute exposure and (*b*) chronic exposure.

5. Establish model animal experiments for acute and chronic exposures.

6. Establish the feasibility of using a screen of several microorganisms, plants, and perhaps human cell cultures for the detection of (*a*) unspecified toxicity, (*b*) specific kinds of toxicity, (*c*) mutagenic activity, and (*d*) carcinogenesis.

7. Search for practical alternatives to major sources of pollution (and then the fun begins) such as fossil fuels and gases versus nuclear generators, the control of hydrocarbons versus carbon monoxide, and levels of particle pollution versus gaseous pollution versus thermal pollution.

8. Eliminate completely those kinds of pollution that are unnecessary. For example, the use of nonlead gasoline would free our city streets of 5 to 10 micrograms per cubic meter of lead.

Reasonableness has aided legislators in formulating legislative restrictions on air pollution, but often the value scale of the cost of remedial action has been more tangible than the suspicion that it is unwise to pollute our constricting world. Eventually one would hope the air entering and leaving a factory, home, or car would have the same quality but this theoretic goal can only be approached, not achieved in most instances.

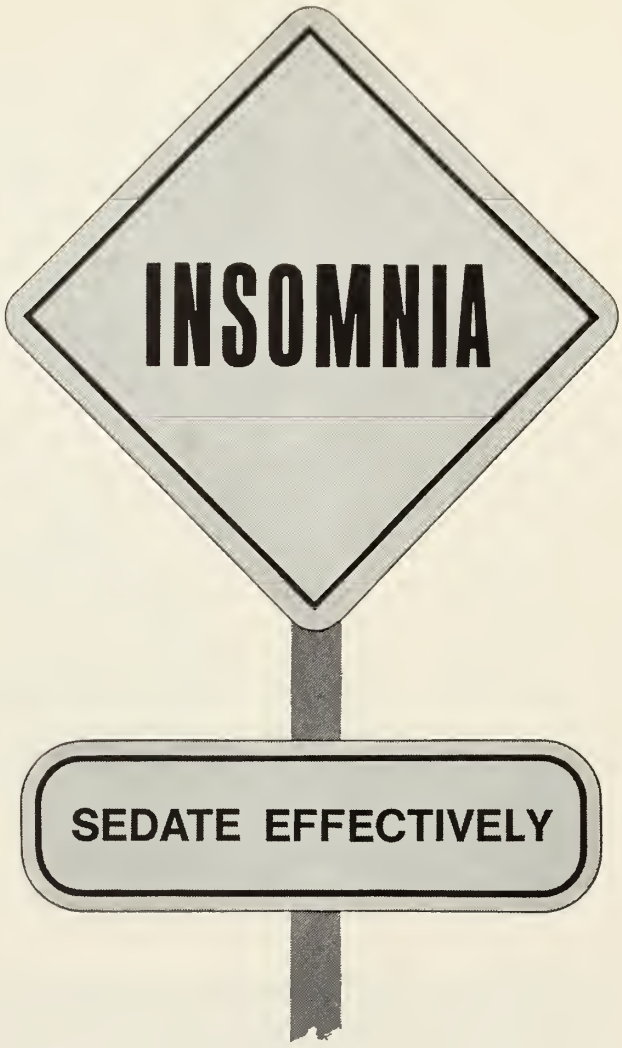
Last, while industry is a convenient and fashionable target for antipollution groups, it would be well to remember individual responsibility. Cars with 25 to 50 horse-power engines would suffice for most activities; burning steaks outdoors is not a critical activity, and cigaret smoking is deadly. As you enjoy a blazing fire in your fireplace, other forms of domestic air pollution may occur to you.

Facts, not polemics, should guide the development of reasonable limitations on the expelling of dirty gases into the environment. Physicians have a personal responsibility in this matter. G. E. M.

Reprinted, Courtesy, *New York Journal of Medicine*, June 15, 1970

Dr. Claude A. McCollough, practitioner in the Salineville community for 46 years, was honored at a public reception sponsored by the local Women's Civic Club.

Dr. Hubert S. Bannings was honored by the Youngstown Optimist Club for recruiting 25 new members for the organization.



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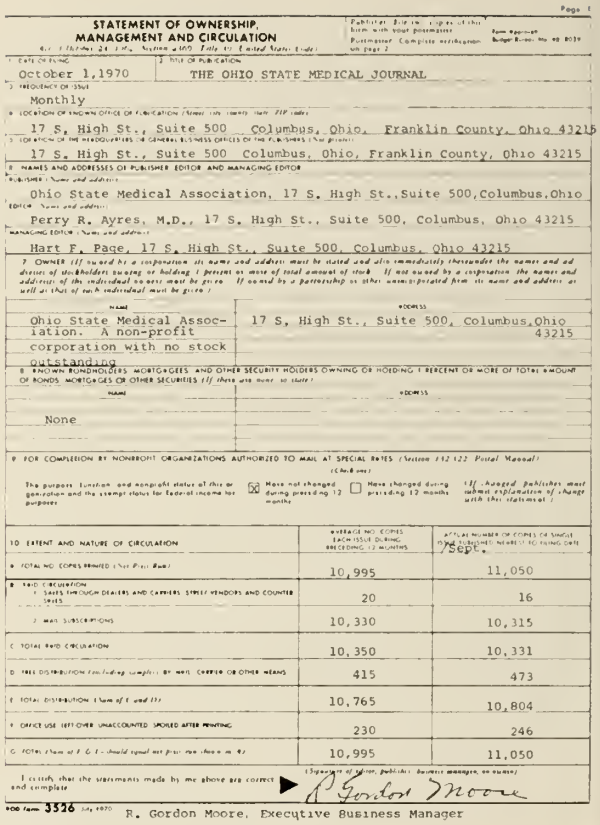
Chairman Is Named for Health Planning Council

Dr. Emmett W. Arnold, director of the Ohio Department of Health, recently announced that Frederick C. Robbins, M.D., dean of Case Western Reserve University's school of medicine, has been appointed chairman of the Ohio Comprehensive Health Planning Advisory Council.

Dr. Robbins, who has been a member of the council since its inception, was appointed chairman for an indefinite term. He succeeds John C. Ullery, M.D., of Ohio State University Hospital, who resigned effective September 15. Dr. Ullery had served as chairman of the council since its initial organization.

Winner of the 1954 Nobel Prize in Physiology and Medicine, Dr. Robbins graduated from Harvard University school of medicine in 1940. He was awarded the Bronze Star Medal while serving in the U.S. Army during World War II and holds honorary Doctor of Science degrees from John Carroll and Missouri universities.

The Comprehensive Health Planning program in Ohio is administered under the Ohio Department of Health and is financed by federal and state funds.



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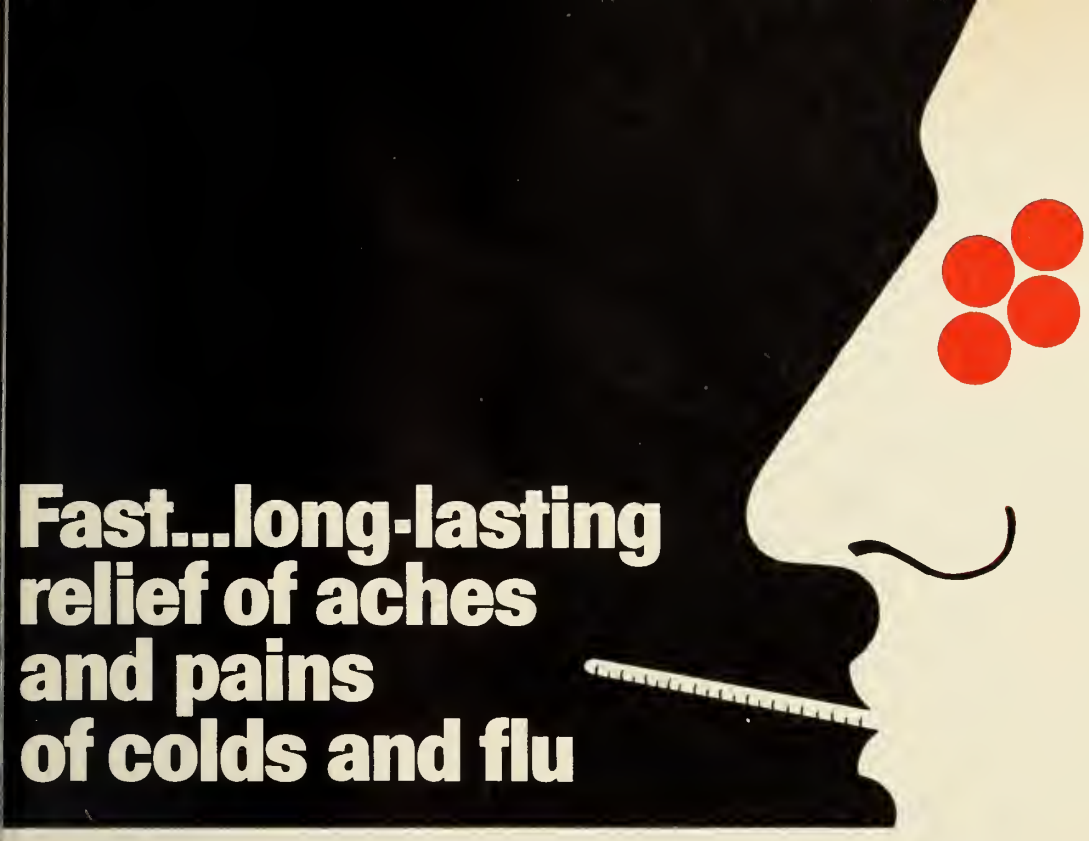
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Compulsion of Tradition Losing Some of Its Force

"Two thousand three hundred and sixty-nine years ago on an Athenian hill, three issues came to judgment: the search for on-going truth versus stagnant orthodoxy; belief in a Supreme God versus a multitude of dieties; and tolerance versus intolerance. When the Athenian people condemned Socrates because of his ideals, they placed themselves on trial forever.

"Today, society is judging the physician and organized medicine; charging rigid orthodoxy, intolerance and refusal to progress. Perhaps time will find our critics, too, are on trial.

"Every age, thank God, is beset with controversy. Without it there would be no change, no growth, no fulfillment of wisdom. And, there is a soundness in the generation bold enough to openly question tradition. Again mankind is in one of its moods of shifting its outlook. The compulsion of tradition has lost much of its force." —F. M. Henderson, M.D., in the *Journal of the Arkansas Medical Society*

Collective Responsibility Begins with Individual Responsibility

"I say that your involvement in your regional council is only part of what you should do.

"More important is that you involve yourself in your own home town planning council. You need not even have a formally organized council.

"Your job is to work in your local hospitals and community planning groups, with your social service department, your health department, your county commissioners, and with other doctors, to devise a local system to get the patient to you; to handle the mechanics of the paper work involved; to enlist, train, and organize the nurses, aides, assistants, and technologists to help you to use your time to best advantage; and to enlist the social workers and community services that are necessary to maintain the health of those you serve. All must realize that you are still the one who must treat the patient.

"The job of your State Society is to help break the bottlenecks at the state and national level that keep you from moving locally." —Louis deS. Shaffner, M.D., in the *North Carolina Medical Journal*

Good Sense of Humor in the Home Relationship

". . . in counseling, physicians must emphasize that the creation of mutual love and respect and trust starts in infancy and should be continued consistently in the day to day relationships within the home. Too often the father has an insignificant role in the raising of children, matters of principle and discipline are left to the mother, when it should be the responsibility of both parents. There is no more rewarding experience in life than raising one's children to become fine, wholesome, useful adults but it must be made perfectly clear that this doesn't just happen. It requires serious thought and effort, a great deal of love, a happy home, consistent principle, good example, and last but not least, a good sense of humor." —*Journal of the Iowa Medical Society*



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OSMA and Ohio Society of Pathologists Promote Proficiency Evaluation Program (PEP) in Ohio

AT THE 1970 OSMA Annual Meeting, the House of Delegates resolved, "That the House of Delegates of the Ohio State Medical Association recommend to its members that those clinicians supplying laboratory services participate in a self-evaluating proficiency program." (Amended Resolution 24-70)

The following statement, entitled "Proficiency Evaluation Program (PEP)" was prepared by the OSMA Committee on Laboratory Medicine in cooperation with the Ohio Society of Pathologists, and was approved by The Council of the OSMA at its meeting on September 19-20. (See page 1128 of this issue.)

* * *

Proficiency Evaluation Program (PEP)

"Quality of living" may well be the cry that sets the tenor for social gains in the 70's. The physician will be continually challenged by those demanding changes in medical care. While some charges are unfounded, the problem of quality in laboratory medicine is definitely before us.

Already, government (us) has moved in an effort to insure payment will be made for quality laboratory service regardless of where offered, rural or urban, hospital or physicians' office. In order for a medicare payment to be made for much of the laboratory services performed (most are usually done in the hospital), the hospital must be approved, either by government or peer evaluation (Joint Commission Accreditation of Hospitals, or Osteopathic Commission Accreditation of Hospitals). Further efforts to upgrade the laboratory area are found in the Laboratory Improvement Act of 1967 covering all laboratory services in interstate commerce. Here again, peer evaluation has been recognized by equivalency of laboratory evaluation programs.

The Accreditation Program of the College of American Pathologists is the only one presently recognized by the Secretary of Health, Education and Welfare as equivalent to governmental inspection programs for interstate commerce. The pathologists have made every effort to help their colleagues evaluate and raise the standards in many hundreds of laboratories, hospital and private, in this country; even the Veterans Administration is having all of their laboratories inspected and hopefully accredited by this national organization.

Efforts do not stop here. Certain criticisms have been raised concerning the last unstudied area, the physician's office laboratory used by him in the care of his own patients. Government officials urge that this area should also be licensed as the fees paid underwrite the demand that quality be the same everywhere. The pathologists are trying to help.

As a first step, Proficiency Evaluation Program (PEP) for his laboratory has been developed by the College of American Pathologists to help him evaluate and probably elevate the quality of his laboratory results. The Ohio State Medical Association during the last session of the House of Delegates urged that a physician participate in a self-evaluation proficiency program for his personal laboratory if he has one. The pathologists of Ohio in further support of physician activities through the Section on Pathology of the Ohio State Medical Association and the Ohio Society of Pathologists have subdivided the State into consultative areas so the physician can obtain advice and counsel if he so desires. Experts in various fields will be available to you locally. In this manner, the pathologists of Ohio hope to preserve further the concept of peer evaluation of the medical profession.

For further information, please contact the OSMA Committee on Laboratory Medicine, Ohio State Medical Association, 17 S. High Street, Suite 500, Columbus, Ohio 43215.

Prepared and Published by The Committee on Laboratory Medicine, Ohio State Medical Association.

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Occupational Health---Concerns and Issues

BAILUS WALKER, JR., M.P.H., AND E. FRANK ELLIS, M.D., M.P.H.

IN THE FINAL THIRD of this century, we are increasingly engaged in a technological revolution, which has tremendous implications for the health of all people, particularly for the health of workers. It has been estimated that every 20 minutes a new and potentially toxic chemical is introduced into industry. New processes and new sources of energy present occupational health problems of unprecedented complexity. Automation makes possible the removal of some workers from hazardous environment and offers new scientific tools for the prevention of disease. On the other hand, it can introduce unexpected or bizarre physical hazards and present new and subtle threats to physical and mental health.

A Review of the Problem

In 1967, there were 27,000 occupational diseases reported in California, a state where such diseases are reportable. If this rate is projected nationally, it can be assumed that there are at least 336,000 cases of occupational disease among the 80 million employed civilians in the United States.[1]

"Black lungs," "grinders rot," "potters asthmas" are ancient terms for progressive crippling lung damage, which has afflicted thousands of workers in the dusty trades over the years. In 1968, the State of Pennsylvania alone paid $55 million in compensation claims to more than 16,000 persons for occupational pneumoconiosis. Among soft coal miners, the disease rate from respiratory disease is five times that of the general working population.

Silicosis, thought to be on the decline for many years, still endangers the health of American metal workers. Over 4,000 cases of silicosis are reported yearly from exposure to free silica, the major constituent of all rocks, soils, sands, and clay.

It has been estimated that about 8,000 carders and 9,000 spinners in the cotton textile industry have byssinosis in any one of its grades. Corrobrating this estimate is the recent study of Zuskin and co-workers[2] at the John B. Pierce Laboratory and the Yale University School of Medicine. These investigators studied workers in

Submitted February 3, 1970.

two mills. Of 158 carders and spinners in both mills, 17 percent had symptoms of byssinosis. The prevalence was higher (25 percent) among carders in both mills than among the spinners (12 percent). Age and duration of employment differed only slightly between the various groups, these factors did not appear to affect byssinosis prevalence.

The authors conclude, "we believe that sufficient information is now at hand to show the need for prevention of byssinosis in the U.S. cotton textile industry. It is not necessary to wait for further research in order to begin a preventive program, even though some questions remain to be answered."

Three and a half million American workers exposed to asbestos face a dual threat: not only are they subject to lung scarring pneumoconiosis (asbestosis) of their trade, but also they are endangered by lung cancer associated with asbestos fibers. Recent studies of insulation workers in two states showed one in five deaths were from lung cancer, seven times the expected rate; half of those with 20 years or more in the trade had x-ray evidence of asbestosis; and one in ten deaths were caused by mesothelioma.

Of the 6,000 men who have been uranium miners, an estimated 600 to 1,000 will die of lung cancer during the next 20 years as a result of radiation exposure in the mines.

Even the old, well-known industrial poisons, such as mercury, arsenic, and lead still offer substantial occupational health hazards. Teitelbaum and Kier[3] recently treated several patients poisoned by arsine gas in the course of their work in the petroleum industry. One of these patients died at once, and one suffered massive hemolysis and renal failure and, according to the physicians, would have died but for exchange transfusion and hemodialysis.

Tanaka and Lieben[4] studied manganese exposure in 75 Pennsylvania industrial plants and found that in 12 plants exposures were in excess of the threshold limit value (TLV). During the course of the survey, seven cases of manganese poisoning, and 15 others, believed to be borderline cases, were discovered.

In many minds, workers who experience occupational health impairments must be employed in heavy manufacturing, mining, or related industry. This was true in the period prior to World War II. But in today's "world of work," no occupation is free of health hazards. With the introduction of new fabrics processed for crease resistance, sales personnel handling such materials have developed eruptions traced to free formaldehyde that is leached from the formaldehyde-resin finish used in the anti-wrinkle process. Similar situations have occurred with anti-mildew, waterproofing, and similar agents.

Much like all occupational skin diseases, most of those affecting service or white-collar workers are caused by chemical agents with mechanical, physical, or biological agents playing a lesser role. Chemicals such as dichromates, resins, plastics, and dyes are among the most frequent offenders and these may act either as primary irritants or as sensitizers. The irritant may cause an eruption at the site of contact in individuals, whereas the sensitizer will not produce a reaction on initial contact but will sensitize the skin so that eruptions occur on later exposure.

The introduction of the automated equipment for a variety of clerical operations has presented new hazards to noise-sensitive white-collar workers. Over 50 percent of the machines in office operations generate noise levels potentially harmful to hearing. While the computer itself may be quieter, sorters and printers used in data processing operations may produce noise in the intensive range of 95 to 100 decibels.

The zoonoses have become, over the years, increasingly identified as occupational hazards. The list includes Q fever in abattoir and rendering plant workers, tick-borne diseases in woodcutters, salmonellosis in food processors, bovine tuberculosis in farmers, Newcastle disease in poultry raisers and processors, contagious ecthyma in sheep shearers, and rabies in veterinarians, as well as field naturalists and dog control specialists. An important recent addition to the recognized occupational zoonoses is infectious hepatitis transmitted to man from subhuman primates. Approximately 80 instances of such transmission have been established by epidemiologic investigation during the last several years. Most of these have involved animal handlers and research biologists and zoologists working with primate colonies.[5]

Social Security data as far back as 1962 show that about 33 percent of all disability allowances to workers were being made for mental, psychoneurotic and personality disorders, or other diseases of the neurosensory system. The people had to be permanently and totally disabled for six months before adjudications could be made. This

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enormous loss of human resources is a grave national problem and one which cannot be divorced from the field of occupational health.[6]

There is growing concern about the mental health of people who work. This interest extends beyond mental disorders specifically related to work situations and includes factors in the work environment, which either enhance or impede the mental status of workers.

Current Efforts

Today there is no such thing as a national program in occupational health. Elements of occupational health are dispersed in several federal agencies, notably, the U.S. Public Health Service, the Department of Interior, and the Department of Labor. State and local occupational health resources have never been commensurate with the needs and size of the work force.

In 1969, the U.S. Public Health Service spent approximately $6.5 million for occupational health activities, and the Labor Department added about $2 million, most of it dedicated to safety procedures with federal contracts.

State and local governments spent approximately $45 million and industry spent $37 million; all of which, by slide rule calculations, amounts to less than $1.30 for each worker in the United States. While all 50 states have workman's compensation laws, they cover less than 65 percent of the nation's labor force. Some 24 states have "elective provisions," for example, employers may accept or reject the compensation laws. Eleven states do not provide full medical coverage for accidental injury, and 22 states give limited or no medical coverage at all for occupational disease. Some 30 states provide benefits which are less than half an injured worker's salary.

Nine states have no identifiable programs in occupational health. In some states, there is exclusive state operation of the occupational health and industrial hygiene program. After almost three decades of exclusive state operation of these programs, it is clear that the services are still somewhat less than adequate. As Dr. Robert Kehoe[7] admits, "Only a minute proportion of our industrial organizations have valid medical information concerning the hygienic status of their employees, while the composite picture of the state of health of our industrial population does not exist even in rough outline. Not only is the incidence of occupational disease unknown—" Kehoe states, "but great areas of information are not under such observation as would provide this information. It is by no means certain, therefore, that the harmful effects of the composite hazards of industry have not exerted important and widespread effects upon the national health, which, because of the brilliant result of our efforts in the field of microbiological prophylaxis and therapy, may have been masked in our gross statistics of morbidity and mortality."

Safety on the job has become one of the most pressing problems in the whole spectrum of occupational health. Here too, very little is known about the problem. In contrast to spending on basic medical research, less than $20 million has been spent in the last ten years on occupational injury-control research.

The lost opportunities for better preventive and community health programs are most glaring in the area of occupational health and safety in small plants. Forty or 50 years ago Geier, McCord, Selby, and other men of vision pioneered in providing high quality, preventively oriented health services for workers in small plants.

Now we find ourselves little farther along the road than we were then, while other countries are moving ahead with substantial progress. In-plant preventive health services are available only to the favored few among American workers. No more than 20 percent of the workers are employed in plants where "employees health services" are provided, and in many cases, these are, for practical purposes, limited to emergency care. Plants employing fewer than 500 employees (and these constitute 99 percent of all establishments and employ three fourths of the work force) usually offer no health services at all. Attempts to reach this population by other community health service technics have been unsuccessful, primarily because no concerted effort has been made to make the necessary services accessible at the workplace or to direct emphasis to the special health problems of people who work.

Needs of Occupational Health

The need for a stronger effort to secure and maintain maximum health among gainfully employed men and women requires no particular justification. The need is obvious. They must be given the same protection against ill health as is enjoyed by other members of our society, but in addition, they require special protection against peculiar health hazards that arise out of and in the course of their work. As individuals, too, and from the standpoint of total national welfare, both in economics and in terms of deeper human values, every opportunity must be taken to raise their level of health, in a positive sense, over and above the mere elimination of negative health factors.

It is estimated that by 1980 the American labor force will exceed 101 million. Government employment is expected to increase rapidly. Rapid growth is also projected in contract construction, and wholesale and retail trades are likely to grow, especially in the durable goods sector including

electrical goods and machinery. Employment in coal mining will probably continue to decline, but quarrying and other mining will increase to hold the level of employment in mining. An increasing number of workers will be in the age group under 25, and the number of women workers will continue to be high. In recent months for example, more than 100 women steelworkers, the first in the United States since World War II, have been added to the labor force. Many of these women are serious about careers as steelworkers. An increasing proportion of the work force will be nonwhite, and a relatively large number of these will be young, relatively unskilled, and inexperienced.

Thus, problems of occupational health will more rapidly increase in importance and complexity. The dispersion and mobility of the service and construction work force; the increase in young, inexperienced workers; the increase in women workers with accompanying biologic and genetic considerations; the movement of workers into new and exotic work environments, and the suspected physiologic and psychologic stresses engendered by technologic change — all of these will pose tremendous problems of occupational health. The very size of the future work force emphasizes the extent of the task ahead.

No more than isolated and somewhat specialized attempts have been made to study the impact of the psychologic and social factors on workers. These have mostly been in relation to control centers, and they have followed the pattern developed in military studies. There is a very wide scope here for studies ranging from the basic aspect of motivation to specific problems of psychologic breakdown. The technics are far from frozen and, in the matter of synthesis, are yet to be worked out. Goals can be pointed out, but the method of attainment will largely have to be developed as the studies proceed. Engineering procedures, such as ventilation, directed air flows, noise suppression, heating and cooling devices, air filtration and precipitation, and regulation of illumination continue to be the mainstay of environmental control practice. However, these need to be reviewed and revised to meet the changing needs of industrial situations, and to incorporate the benefits of technologic advances. Associated with this more classical type of engineering are the newer technics often termed "human engineering," in which the design of tools, machines, procedures, and installations is adapted to the characteristics and capabilities of the worker who operates them to maximize his effectiveness and to minimize the stress placed upon him. Both classical and human engineering must find a prominent place in principle and practice of industrial health engineering.

The pursuit of these studies or the implementation of comprehensive occupational health programs require many technics, items of information, points of views, or specialized knowledge, which are seldom acquired in the course of routine professional training for engineers, physicians, nurses, or scientists. It is essential that there be some system whereby this training can be provided in conjunction with the regular professional training, as postgraduate courses or on the job. A few universities offer postgraduate courses in industrial medicine, occupational health, or industrial hygiene, but these require one or more academic terms of full-time instruction, and are not sought by many students. The Public Health Service provides one- or two-week technical courses for industrial hygienists, industrial engineers, safety engineers, and plant medical officers. These courses are usually oversubscribed. There is an obvious need for providing still more short-term classes and for cooperation with universities in attracting more students to long-term professional courses. Even with such an expanded effort, professional industrial health workers will still remain in short supply, and it will be essential to develop in the occupational health field a supportive corps of paraprofessional personnel, who are competent to perform scientific tasks.

Perhaps no area of community health services has stimulated so wide a range of professional interest as has the field of occupational health. No subject field is impinged upon by more professional organizations, voicing their concern and attempting to remedy the existing situation. Moreover, it is difficult to conceive of a subject which more directly involves the interest of all sectors of the American social and economic scene than occupational health.

In face of this interest and activity, there is an urgent need to bring these concerns into focus and to assure the social and economic benefits that can be achieved by a broad attack upon problems of the worker's health.

One cannot escape the conclusion that the Federal Government has a definite responsibility in this field. Occupational health and safety in modern industry are not the problems of a single employer, a single industry, or a single state or local jurisdiction. But the matrix of concern indicates an opportunity for development of a national program as a partnership undertaking, in which the Federal Government will make substantial contribution through leadership and support, and in which a coordinated effort can be expected from labor, industry, state and local governments, and professional communities.

The development of occupational health programs at the state and local levels as part of the total community health effort, with adequate funds and staff, is essential if there is to be an

effective partnership in a national program of occupational health. Few state and local jurisdictions have adequate legislative or regulatory authority, and major shortcomings continue to be lack of trained personnel and inadequate budget.

With adequate assistance and guidance, the state and local jurisdictions can develop comprehensive occupational health programs. If these agencies are to serve on the "firing lines" of a vigorous program of occupational health, their early support must come from the federal level, where trained specialists and funds should be available to provide assistance to identify and solve problems for the total health and welfare of workers.

Summary

In today's "World of Work" no occupation is free of health hazards. New processes and new sources of energy present occupational health hazards of unprecedented complexity. Introduction of new fabrics have brought about increased occupational skin disease, not only to factory employees, but to sales personnel as well.

Along with the new hazards, there are the traditional hazards of occupational health; increased occurrence of the zoonoses and occupational diseases such as silicosis, byssinosis, and asbestosis. Arsenic, mercury, and lead poisoning still offer substantial occupational health hazards. The 3½ million American workers subjected to asbestosis are also endanged by lung cancer associated with asbestos fibers.

Additional problems can be anticipated with an increase in the American labor force. By 1980, this will consist of more than 101 million workers. The majority of this increase will include nonwhite, young, female, unskilled, and inexperienced workers.

Occupational health and safety of employees are not the problems of one facet of society, but rather an involvement of all; labor, industry, state, local and federal governments, and the professional community, with the federal government making substantial contribution through leadership and support.

However, there is no clearly defined national program of occupational health. Of the states and local communities which do operate such programs, their services are somewhat less than adequate.

The need is urgent for such a national program, including health services, research, and training to promote the health and welfare of workers.

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LEGAL RELATION OF PHYSICIAN TO HOSPITAL. — Hospitals are categorized as proprietary, public, and nonprofit. Nonprofit hospitals, the mainstay of our hospital system, traditionally have been accepted by law as private institutions, and, as such, their operation has been held to be the duty of their governing boards. The medical staff has not been held to enjoy legal rights in the management of such hospitals, and courts have been reluctant to interfere with their internal affairs.

Recently, the increasing importance of hospitals to medical practice, and the financial support that they receive from both government and community, have caused courts in some states to rule that the actions of nonprofit hospitals are reviewable by the courts. In spite of this desirable trend, physician privileges in nonprofit hospitals require more effective and practical protection, either through legislation or through more aggressive action of hospital accreditation bodies.—J. A. Fabro, M.D., Torrington, Conn.: *The New England Journal of Medicine,* 281:706-713, Sept. 25, 1969.

Management of Depressed Patients

A Discussion of Some Problems in Psychotherapy

Norman S. Brandes, M.D.

THE PRESENTING HISTORY of a seriously depressed patient would be something like the following: apprehension that something terrible is going to happen, chronic worrying that is becoming worse, feelings of hopelessness, loss of appetite, insomnia, inability to concentrate, a loss of interest in former activities and present work, and increasing time spent in isolation from others, especially isolation in the bedroom. Along with these symptoms, the patient usually has multiple physiological anxiety complaints such as excessive sweating, rapid pulse, feeling of faintness, rapid breathing and a choking or painful sensation in the chest. Sometimes the depressed patient arrives in a psychiatrist's office feeling quite desperate and the patient's desperation and subtle or overt sense of hopelessness can spread over the room like a black cloud.

When the psychiatrist is confronted with a patient that feels desperate and lonely, then his own anxiety goes up as a reaction to these feelings. The natural result of the healer's anxiety produces the urge "something has to be done." Most often, an antidepressive drug of one type or another is immediately prescribed for these patients. Drugs may or may not help the patient but can at least help the physician to feel better, because he is doing "something." Therefore, there is less anxiety in the therapy session, and more energy can be devoted to therapeutic interaction.

Often these patients are admitted to a psychiatric unit immediately, if not sooner; then, within a very short period of time, they are given shock therapy. Electroshock therapy for depressives has advantages for some, inasmuch as it tends to bring about repression of memory. It also seems to serve as some sort of a punishing experience. ("Killing the patient for being a sinner, followed by rebirth, namely, coming out of the shock coma.") This symbolic dying and being reborn again can occur as many as 6 to 12 times during the hospitalization. Some of these patients have a good response to shock therapy, and it is quite possible that they can return to their work and usual activities after a short rest period. Others find their way into repeated shock therapy hospitalizations and some of these patients are readmitted as many as three or four times for shock treatments (over a period of five to ten years). It's almost as if they have to be shocked to have "their battery recharged." Unfortunately, as these patients become older, they become quite discouraged with their unresolved problems of living and may commit suicide or develop shock resistant illnesses that require permanent institutional care.

The premorbid history of the depressed patient varies considerably. Usually, there is a background of exposure to parents who were either depressed, themselves, or parents who were disapproving, overcontrolling, and/or who used guilt instillation as a means of setting limits and controlling behavior. Depressed patients have a distorted, oversensitive meaning of what it means to be rejected. Some of them have always had problems relating to others and complained of the feeling of rejection by others since childhood

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days. Most depressed patients have difficulty forming satisfactory intimate relationships, especially with the opposite sex. Often, they have had a long history of feelings of inferiority and inadequacy regarding their sexual identity despite positive experiences in the past. It is not uncommon to run across successful executives and professionals with outstanding performance records, who are convinced that they really have not accomplished anything worthwhile in life and that they are real failures—that all is lost, they are "over the hill."

The selection of psychotherapy as the treatment of choice for the depressed patient rests on many factors. For example, the age, intellectual ability, motivation, and presence or absence of additional problems such as alcohol or drug dependency, all play a role in determining the choice of psychotherapy as the chief treatment modality.

For the suitable patient, the type of psychotherapy that should be administered is analytically oriented and dynamic. During weekly sessions (semi-weekly, even tri-weekly at first) probing into the past and present life of the patient attempts to reveal insights for both patient and therapist. The therapist depends on his relationship with the patient to see the patient through anxieties developed in learning about himself. The following exchange with the patient in an early therapy session may illustrate this point:

Patient: I feel terrible again. I don't understand it—I feel something very bad is going to happen, I don't know what—

Therapist: Perhaps we can talk about that later in the session, today. Last time you were telling me about your parents.

Patient: Where should I begin?

Therapist: Try to just sit back and talk about whatever comes to mind about your parents.

Patient: Well—I didn't play with the other kids—they were playing football or baseball and I had to stay inside and do my homework and practice the piano. I watched from my window. My mother was very dominating. She controlled my father and she controlled me.

Therapist: What did your father do about this?

Patient: That's the trouble—he didn't do anything. He let her run his life and he let her rule me.

This patient, who was 38 years old, then went on to talk of his hostility for his father for being passive to the domination of his overcontrolling mother. This hostility, as it turned out in subsequent sessions, first began to show itself shortly before the father's death (the result of an automobile accident). The patient felt guilty that his father died before feelings could be resolved about this part of his life. It was almost as if he "wished his father dead" and it magically happened. Incidentally, this patient's chief complaint at the time of his first visit, in addition to experiencing a depressed state of being, was—a dread of driving an automobile. Nothing was really connected to the death of his father until the eighth or ninth therapy session.

The revelation of a significant dynamic area in the therapy session doesn't bring about a "cure" of the patient. First of all, there are usually other areas that must be explored in both the past and present that might be involved in the patient's guilt. Secondly, understanding the background of why he does things (insight) is not enough to change present behavior. The patient must be shown time and time again, if necessary, the explanation of a certain mode of thinking, feeling or behavior and must then be encouraged and helped to find ways to work through the conflicts. The process of working through (overcoming resistance to making changes in the way problems are handled) is one of the most difficult tasks in therapy.

There are other difficulties in the work of psychotherapy. The demands made upon the therapist by the depressive during a course of psychotherapy can be great and bring about negative reactions in the therapist. The feelings and behavior of the therapist to the patient are called "countertransference." In the proper psychodynamic training and supervision of the student of psychotherapy, countertransference is studied and evaluated carefully, and the student is helped to understand this very important part of psychiatric practice. Unless the therapist is aware of his significant feelings and reactions to his patients (countertransference), psychotherapy becomes complicated; as a matter of fact, the efforts of psychotherapy can be in vain because of the complications that occur as a result of distortions that go on in the therapy relationship.

The following remarks are concerned with other factors that tend to cause significant reactions in the psychiatrist in the long term management of the depressed patient. In particular, those factors that cause "annoyance" and increase the level of anxiety of the therapist are of particular concern.

Depressed patients are usually ambivalent, that is, they have difficulty making up their minds. Very often, they won't make a decision and sometimes they can't make a decision. After a period of time, say six months to one year of therapy, this inability to "make up their minds" may cause impatience and even angry annoyance in the therapist.

The depressed patient tends to produce depression in others and causes similar feelings of depression in the therapist. One of the play-it-by-

ear criteria in diagnosing a depression is this phenomenon of counterdepression. When the therapist becomes aware that his patient is causing depressed feelings in himself, he may very well resent that patient and that particular time. "My God—Mrs. ———— is due here at 11 AM—that will ruin the whole lunch hour."

The depressed patient places a great responsibility on the shoulders of the therapist. He hands the therapist his life, and the success of therapy becomes a matter of life or death, since a depressed patient can commit suicide. To have the burden of seeing to it that a patient does not take his own life can be quite heavy. The suicide of any patient is always painful, but it becomes especially agonizing, when over a period of time, the therapist becomes close to and fond of the patient.

Depressed patients are prone to attribute omnipotence to the therapist. They give the therapist the godlike feeling that he is all-powerful and that somehow he will determine their fate and bring about a happy ending to the therapy. The psychiatrist can sometimes get carried away by feelings of being "all-powerful" in the patient's life and set about overcontrolling the patient as a paternal deity would do.

After a period of time, it is not uncommon for the depressed patient to overcome his reluctance to form a close intimate relationship with another, and usually he reaches out for this closeness and intimacy with the therapist. The patient may transfer feelings to the therapist (previously held for other significant individuals), and this transference of feelings can become "I love you - - I adore you - - the sun rises and sets with you." Although not to the same intensity, the psychiatrist can countertransfer similar feelings to the patient so that he finds himself scheduling the patient just before lunch hour and then extending a session or seeing the patient more often than he should. The loss of objectivity that results from this kind of therapeutic situation interferes with a realistic appraisal of the patient's progress in therapy.

Along with various transference reactions (transferring feelings for others to the therapist) is the tendency of these patients to place therapists in the position where they simply have to feel and react positively toward their patients, because not to feel and behave in a positive manner means rejection. Reacting with any sort of rejection to a depressed patient can increase anxiety levels for both, since the patient will tend to become more depressed, and the risk of a self-destructive act is greater.

This discussion of transference and countertransference problems the psychiatrist faces when he undertakes the psychotherapy of a depressed patient demonstrates some of the more significant difficulties encountered with the use of this treatment modality. Despite the challenge of these difficulties, psychotherapy that is dynamic in emphasis and psychoanalytic in orientation appears to be the treatment of choice for the anxiety-ridden depressive reaction, since it provides opportunity for strengthing the ego and changing the behavior.

ALMOST ALL SUICIDAL PERSONS who consult physicians wish to live. Generally they fall into one of two groups. Interpersonal suiciders manifest frequent threats and attempts, are emotionally labile, have ill-defined suicide plans, and clear ideas as to how their crises might be resolved. Intrapersonal suiciders are less open in manifestations of suicidal drive, withdrawn rather than emotional, often have clearly formulated suicide plans and do not have ideas (other than suicide) as to how their crises might end. The suicidal situation results from two factors: (1) the loss of some valuable person or commodity, and (2) the loss of self-esteem. What ensues is temporary character disorganization—crisis. Treatment is based on restoration or replacement of lost objects and building up of self-esteem.—Norman Tabachnick, M.D., Los Angeles: *California Medicine,* 112:1-8, June, 1970.

Women's Magazines

VS

Public Opinion

David E. Schuller, B.A., John C. Ullery, M.D., and Garth F. Essig, M.D.

A Survey Describing the Significant Impact of Women's Magazines on Public Opinion and Use of Oral Contraceptives

ORAL CONTRACEPTIVES have been a popular discussion topic ever since they were made available to the general public in 1961. Within the past two years, articles concerning oral contraception have become commonplace in the various news magazines, especially those catering to the female population. Much of this publicity has emphasized the adverse effects of birth control pills. Some of these articles have been less than completely objective. For example, issues of *Ladies Home Journal* have included articles entitled "Why Doctors are Losing Faith in the Pill,"[1] and "The Terrible Trouble with the Birth Control Pills."[2] Drew Pearson recently reported in his syndicated column that, "at least 10 percent of all adverse-reaction reports are fatalities and that one third of the recent reports on one specific pill involve death."[3] In the article describing the medical professions' loss of faith in oral contraceptives, the reporter writes that, "Physicians do not like to talk about it — except among themselves — but an increasing number are taking their own wives and daughters off the pill."[1] It is evident that much of the literature on oral contraception that has appeared in lay magazines can be more suitably described as editorial rather than objective reporting. With the realization of how birth control pills are being presented to the public, a questionnaire was prepared in an attempt to determine if these articles have influenced public use or opinion of oral contraceptives.

Submitted March 11, 1970.

Methods

The pilot survey was conducted in the married housing area of The Ohio State University. It involved 75 women who anonymously completed the questionnaires, which were distributed on a door-to-door basis. The results from this pilot study encouraged an expansion of the survey and enlargement of the sample size. The questionnaires, placed in the offices of six obstetricians and gynecologists located throughout the city, were anonymously completed by each teenage or adult female who entered the offices. The questionnaires were distributed over a ten-week interval.

The statistical significance of the percentage of "Yes" or "No" replies was based on the hypothesis that an inclusive distribution would be characterized by a percentage of "Yes" replies which was equal to the percentage of "No" replies. The final percentages for each question were tested against the 50 percent figure in order to ascertain whether these differences could have resulted from chance alone. Using the equation $Z=(p=.50)/\sqrt{p(1-p)/N}$, where p = proportion in first category (e.g. #5, p=.549) and n = sample size (e.g. #5, n=588), it was determined that there was a chance of 5 percent (e.g. signifi-

cance at the 5 percent level) or less that these percentages resulted from random selection alone for every question, except question 7.

Results

The sample, including the 75 questionnaires from the pilot study, involved 630 women.

AGE

Their ages ranged from 15 to 57 years. The average age was approximately 26, with 74.9 percent between 20 and 30.

CHILDREN

The number of children ranged from zero to 11 per woman. The group of women with no children (40.2 percent) represented the largest segment of the total, when they were divided according to number of children. Some 94.7 percent of the entire sample is included in the groups with three children or less.

MARITAL STATUS

The majority (85.7 percent) of those interviewed were married.

EDUCATION

The educational experience varied from women who had only completed the fifth grade to those with masters degrees. Of the total surveyed, 11.1 percent were not high school graduates, 42.4 percent were high school graduates, 24.1 percent had some college experience, and 21.4 percent were college graduates at either the bachelor or masters level.

OCCUPATION

About 51 percent of the women were housewives. Teaching was the second most prevalent occupation (5.9 percent), and secretarial work was third (5.6 percent). A variety of occupations was represented (i.e. deputy sheriff, locksmith, model fashion coordinator, towel folder, artist, wig stylist, writer, etc.).

Tabulation of Responses

The responses to the questionnaire are as follows:

1. *Do you, or have you ever used birth control pills?*

	No. of women	Percent of total answers
Yes	459	72.9
No	170	27.1
No Answer	1	

2. *Do you periodically read any news magazines (i.e. Look, Time, Newsweek, Ladies Home Journal, Redbook, Good Housekeeping, McCalls etc.)?*

Yes	576	91.5
No	53	8.4
No Answer	1	

3. *Have you recently noticed the frequency of articles on birth control pills in these various magazines?*

Yes	556	88.9
No	69	11.1
No Answer	5	

4. *Do you think these articles stress the adverse effects of birth control pills?*

Yes	445	76.3
No	138	23.7
No Answer	47	

5. *Have these articles influenced you so that you: (circle one)*

   a) *Believe the adverse effects outweigh the contraceptive benefits?*

   No. of Affirmative Responses
   (a) = 122
   122/323 = 37.8 percent

   b) *Have stopped using birth control pills because of the adverse effects reported in these articles?*

   (b) = 44
   44/323 = 13.6 percent

   c) *Have consulted a physician with respect to the reported adverse effects?*

   (c) = 157
   157/323 = 48.6 percent
   resulting in (underline one):
   1. *discontinuation of use*

   No. of Affirmative Responses
   (1) = 46
   46/157 = 29.3 percent

   2. *continuation of use*

   (2) = 65
   65/157 = 41.4 percent

   3. *plans to use in the future*

   (3) = 46
   46/157 = 29.3 percent

   d) *Have not changed your opinion*

   (d) = 265
   265/588 = 45.1 percent

   Question Not Applicable—12
   No Answer—29

6. *Do you occasionally take aspirin or some aspirin-containing compound (i.e. Bufferin, Excedrin, Darvon Compound, Anacin, etc.)?*

	No. of women	Percent of total answers
Yes	588	93.5
No	41	6.5
No Answer	1	

7. *Are you aware of any possible adverse effects of aspirin?*

Yes	296	47.4
No	328	52.6
No Answer	6	

8. *Have you recently read any magazine articles (not advertisements) concerning aspirin?*

Yes	76	12.2
No	549	87.8
No Answer	5	

a) If "Yes," do these articles (underline one):

1. stress the effectiveness

No. of Affirmative Responses

(1) = 31

2. stress the adverse effects

(2) = 25

3. stress neither effectiveness nor adverse effects

(3) = 16

4. stress the effectiveness and the adverse effects

(4) = 2

No answer to 8a = 2

Comment

It is necessary initially to explain the means of data collection. This survey was not intended for the general female public. It has been directed to those women who most likely would be regular readers of the news and women's magazines. Therefore, the questionnaires were placed in an environment (i.e. private practitioners' offices) that would give a higher yield of magazine readers than other segments of the population. The results of this survey, therefore, do not apply to the general female population but rather to a population of women in which, according to question 2, the percentage of magazine readers is 91.5 percent and the proportion of those who have had personal experience with birth control pills is 72.9 percent.

Questions 3 and 4 reveal that 88.9 percent (significance at the 1 percent level) have noticed the frequency of articles concerning oral contraceptives and 76.3 percent (significance at the 1 percent level) feel that these articles have stressed the adverse effects.

Since some of the women in the sample did not read any of the magazines, they could not respond to question 5. The total number of applicable responses to this question was 588. As one inspects question 5 (i.e. Have these articles influenced you so that you: (a) believe the adverse effects outweigh the contraceptive benefits?, (b) have stopped using birth control pills because of the adverse effects reported in these articles? (c) have consulted a physician with respect to the reported adverse effects resulting in: (1) discontinuation of use, (2) continuation of use, or (3) plans to use in the future, (d) have not changed your opinion), it becomes obvious that the sum of choices (a), (b), and (c) represents the total number of women who were influenced by these magazine articles. This sum represents 54.9 percent (significance at the 5 percent level) of the total number of applicable responses. The percentage of women who did not change their opinion after reading these articles (i.e. selecting choice "d" to question 5) is 45.1 percent. These articles had a strong enough influence on the reading public to alter the opinions of approximately 55 percent of those interviewed concerning the adverse effects of oral contraceptives.

Further examination of this group (54.9 percent), which was influenced by the articles, describes more specifically the extent of impact these articles did have. Of those influenced by the articles, 37.8 percent now believe the adverse effects outweigh the contraceptive benefits. A surprisingly high percentage (13.6 percent) have stopped using oral contraceptives solely on the basis of the adverse effects reported in these articles without asking the advice of a physician. However, 48.6 percent found it necessary to consult a physician with respect to the reported adverse effects.

The final decisions regarding the use of oral contraception by those who did consult a physician is interesting in that only 29.3 percent decided to discontinue using the pills after talking with a physician. In contrast, some 41.4 percent continued using them and 29.3 percent planned to use them in the future, thus totalling a significantly greater figure of 70.7 percent (significance at the 1 percent level) who decided not to

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stop using oral contraceptives after talking with a physician.

The general interpretation of question 5 suggests that a substantial percentage (54.9 percent) of the population was influenced by these articles, some (13.6 percent) to such an extreme that they have stopped using oral contraceptives based exclusively on the information presented in lay magazine articles. Almost half (48.6 percent) of those influenced were concerned to such an extent that they sought medical advice. Personal medical consultation appeared to have a somewhat calming effect on these women, with the result that 70.7 percent did not discontinue using birth control pills after talking with a physician.

Questions 6 through 8 were designed in an attempt to gauge public awareness of the hazards of medications in general. Aspirin-containing compounds, whose many adverse effects are probably better defined than those of oral contraceptives, were used as a representative medication. The response to question 7 is at a significance level which is greater than 10 percent, thus restricting any interpretations of the response. However, question 6 reveals the somewhat expected results that more women are using aspirin-containing compounds (93.5 percent) than oral contraceptives (72.9 percent). The small percentage (12.2 percent) of affirmative responses to question 8 (i.e. Have you recently read any magazine articles concerning aspirin?) when compared with the larger percentage (88.9 percent) of affirmative replies to question 3 (i.e. Have you recently noticed the frequency of articles on birth control pills in these various magazines?) reveals that the news magazines, at best, only minimally are informing the public of the adverse effects of a drug which has a substantial number of adverse effects and is being used by a larger segment of the population than the users of oral contraceptives. Whether these results represent selective reporting aimed at public appeal cannot be established on the basis of this survey.

Summary

A questionnaire, attempting to determine if lay magazines had influenced public opinion of oral contraceptives, revealed that 54.9 percent changed their opinion concerning the adverse effects after reading these articles. Of those influenced, 13.6 percent stopped taking oral contraceptives based entirely on the adverse effects reported in these articles, and 48.6 percent sought medical advice. However, medical consultation concerning these reported adverse effects resulted in 70.7 percent of this group deciding not to discontinue oral contraceptives. The questionnaire attempted to gauge public awareness of drug hazards, using aspirin-containing compounds as examples. In the sample, 93.5 percent were using aspirin-containing compounds, whereas 72.9 percent were using oral contraceptives. However, only 12.2 percent stated that they had read any lay articles concerning aspirin-containing compounds, whereas a significantly larger 88.9 percent stated that they had read articles about oral contraceptives.

Acknowledgment: The authors would like to thank Carole Schuller who aided in this investigation by compiling the data from the questionnaires.

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THE INCIDENCE OF ASPIRIN INGESTION during the week preceding overt gastroduodenal bleeding was recorded in 582 patients. A positive aspirin history was found in 80 percent of patients with acute gastic lesions, in 63 percent of those in whom no lesion was found, in 52 percent of those with a chronic duodenal ulcer, and in 49 percent of patients with a chronic gastric ulcer. In a control series of 542 consecutive patients without overt bleeding admitted to the same wards during part of the time of this investigation the aspirin incidence was 32 percent.

The difference in aspirin habits between these two series confirms that aspirin is a factor in precipitating overt hemorrhage in acute and chronic peptic ulcers, and that it is an important cause of bleeding from the stomach or duodenum, or both, in the absence of a chronic peptic ulcer. — H. B. Valman, M.B., M.R.C.P.; D. J. Parry, M.B., M.R.C.P.; and N. F. Coghill, M.B., F.R.C.P., Middlesex, England: *British Medical Journal,* 4:661-663, December 14, 1968.

Chronic Serous Otitis Media

E. R. Hargett, M.D.

THIS DISEASE is of general importance because deafness is its chief symptom. The words congestive and mucoid are interchangeable with serous, indicating that the main feature of the condition is a mucous mass filling the middle ear. The drum is intact, dampening the auditory vibrations even more effectively than a mass of cerumen filling the external canal. The disease is especially tragic in children, as it interferes with their educational and personality development. It is also hard to treat in the young, as they do not readily cooperate in nasal instrumentation. The condition is a secondary one, being the result of disease extending through the eustachian tube to the middle ear. Adenoiditis and sinusitis are the chief primary causes. Adenoiditis is easily dealt wth, and adenoidectomy produces some quick and permanent cures.

It is sinusitis as the cause that I am concerned with in this article, and the following case report is typical of the problem and its solution.

Case Report

A 12-year-old boy was tested by the school system and found to have significant hearing loss bilaterally. His tonsils and adenoids were removed. No improvement was noted, and tubal inflation was tried, still with no improvement. Radiation therapy was discussed and rejected. Also considered were the various surgical procedures, including the insertion of a bobbin ventilation tube, but these were not acceptable to those concerned. The next standard step was the recommendation of a hearing aid. At this point displacement suction irrigation of the infected nasal sinuses was tried, the diagnosis being confirmed by noting pus being discharged from the ethmoids on both sides. A solution of 1 percent salt and .025 percent prednisolone was used, with suction of 100 mm. of mercury, alternating sides. The child stated at once that he felt the medicine in his ears, and improvement was noted after the second weekly treatment. After eight irrigations, the school system test showed the patient's hearing was within normal limits. Several monthly prophylactic treatments have been given, and the hearing has remained normal. He was checked monthly at first, then the interval between visits was lengthened.

Comment

I had observed that an occasional case showed improvement, especially those with an allergic component, after use of ordinary nose drops. Therefore, it was reasonable to expect better results with deeper penetration into the sinuses, as is possible using displacement sinus suction irrigation.

Submitted April 29, 1970

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Serous Otitis Media in Children

Importance of Prevention and Early Diagnosis

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THERE IS NO PATHOLOGIC entity in children less understood and more frequently mishandled than serous otitis media, also known as secretory otitis media, nonsuppurative otitis media, glue ear, mucinous otitis media, catarrhal otitis media, exudative otitis media, and by several other names. Even the name serous is questionable, because there are controversial opinions as to whether the fluid in the middle ear is a transudate or an exudate.[1] Well known is the damage done to the hearing of a child when large or infected adenoids mechanically block and chronically infect the middle ear through the eustachian tube, but, the etiology and mechanism of effusion of the middle ear are more complex and not so well understood. One of the often supported theories regarding the etiology of serous otitis media is insufficient treatment of acute or subacute infections of the ear not only with insufficient doses of antibiotics but, more important, with insufficient duration of the treatment.[2]

It is now clearly established that any infection of the upper respiratory tract affecting the ear needs to be treated with adequate doses of antibiotics for at least ten days. The increased incidence of serous otitis media found today in the childhood population between five and ten years undoubtedly may be attributed to the treatment of upper respiratory infections with the two- to four-day course of oral antibiotics, even worse with sulfa drugs, and very often with a simple "shot of penicillin."[1,2]

Allergy is a frequent cause of eustachian tube congestion, obstruction, and middle ear mucosa swelling with subsequent ear effusion.[3] Recurrent and frequent virus infection is a paramount factor in serous effusion,[2] and mechanical obstruction with large and infected adenoids completes the picture of the typical cause of effusion in the young child. If to all or some of these causative factors we add the insufficient treatment with antibiotics, we can understand why we are finding serous otitis media more and more frequently in children below 10 years of age.

A typical case is a child with large tonsils and adenoids with frequent attacks of inflammation and mild involvement of the ears usually manifested by some earache and loss of hearing, and this last symptom is seldom revealed by the child or detected by the mother. In many cases, the tonsil infection has passed unnoticed because a young child seldom complains of a sore throat. If the attending physician is a conservative one, who believes that tonsils and adenoids must be kept in their place and be removed only in extremely severe and repeated infections, the child most probably will develop an ear effusion with a mild loss of hearing, which will increase slowly and not be detected until the school years when a teacher will suspect the loss of hearing and a school nurse will confirm it through an audiogram.

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At this time, the child will have a 25 to 30 decibel loss and an effusion which has developed over two or three years. This is why most serous otitis media cases seen by otolaryngologists are referred by school nurses.

Some of these children have had tonsillectomy and adenoidectomy one or two years previously, which means that the operations may have been performed too late and concomitant factors in the establishment of the ear effusion have been neglected or underestimated. At the present time, the danger of a permanent loss of hearing, no matter how slight, is so important that the conservative approach with regard to tonsil and adenoid surgery poses a real threat to the hearing of many children.

Main signs of effusion are: conductive deafness, but it is not rare to find a perceptive loss, especially in high pitch frequencies;[1] retracted membrane; hairline or bubbles visible through the membrane; dark appearance of the membrane on the affected side as compared with the normal; alteration in the mobility of the membrane visible with the Siegle suction speculum; [2-4] pain or earache, which is very uncommon; and, tinnitus, which may occasionally be present and is much more common in older children and adults.

Litton and MacCabe (1962) found, in examination of about 10,000 children, more than 2.5 percent to be deaf and more than 40 percent of the deaf to have middle ear effusion.[5] Lemon (cited by Hollander)[6] pointed out that, in 5,000 children referred for tonsillectomy and adenoidectomy, nearly 20 percent had serous otitis media.[2]

With a suspected hearing loss in a child, it is advisable to presume that fluid in the middle ear may be the cause until the contrary is proved.[1] In children of early school age, a conductive loss of 25 decibels or greater at 500 to 3000 cycles per second represents a significant physical handicap. Hohn and Kunze have shown that speech development is significantly delayed with such a conductive hearing loss.[7]

Prolonged negative atmosphere pressure in the middle ear, which invariably occurs in the presence of exudate, leads to irreversible changes: indrawing of the tympanic membrane and its adherence to the middle ear structure (the incus and promontory), possibly dislocation of the incudostapedial articulation, atrophy of the tympanic membrane, and eventually to permanent hearing impairment.[8] In the young child, the negative pressure leads to retardation of development of the air cell system.[9]

In serous otitis media, the mucosa of the middle ear undergoes a columnar metaplasia with replacement of the flattened endothelium-like cells with columnar ciliated respiratory-type epithelium. Under favorable conditions, this state may revert to normal but there must be a critical period in the development of this chronic mucosa change beyond which regression to normal is improbable.

In case of nonperforated middle otitis with antibiotic treatment by mouth, sufficient concentration for an adequate length of time at the site of the infection is not achieved. The emergence of resistant strains of bacteria is thus encouraged, and the foundation of a chronic infection is left. Later, this becomes a sterile effusion. The main characteristic of this effusion is its insidiousness. There is no earache and there is no complaint of loss of hearing by the child. Children are never concerned about unilateral loss and mothers seldom detect unilateral loss. Bilateral loss is also very often undetected until it reaches 20 or 25 decibels, and even in these cases, many mothers will not suspect the loss. The early recognition of secretory otitis media is of utmost importance in relation to prognosis, but more important than its recognition is its prevention.[1] In upper respiratory infection with ear involvement, revision of tonsils and adenoids, septum, and a possible sinus infection are important. Children may have sinusitis, which is very often overlooked. Investigation of a possible allergy and causes of the recurrent upper respiratory infection and a liberal approach to the surgery of tonsils and adenoids in a child with recurrent tonsillitis and adenoiditis is very important.[1]

Generally speaking, prevention of serous otitis media may be accomplished by: first, intense treatment of upper respiratory infections in cases where the ear is affected, and this is more often the rule than the exception[1] (adequate means enough high doses at regular intervals to keep a sufficient concentration of antibiotics in the mucosa of the ear cleft for a period of no less than ten days—it is obvious that a "shot of penicillin" and a four-day course of oral penicillin administered only during the day is the right prescription to induce serous otitis media); second, by complete treatment of a possible allergic condition of the child; third, by elimination of infected tonsils and hypertrophoid adenoids. There is no justification for keeping a child for years with recurrent tonsillitis and adenoiditis, when concomitant with this condition serous otitis media is developing. Later when the tonsils are removed, it could happen that the serous otitis media is so advanced that permanent loss of hearing is already established.

In normal persons, the patency of the eustachian tube is affected by the body position. At 20 degrees the ventilating is two thirds of that in the erect position. When the elevation of the body is below 20 degrees, as happens when the child is in bed, the ventilating capacity of the tube is reduced to one-third. In the horizontal position, when there is congestion of the nasopharynx, as happens in upper respiratory infections, obstruction of the eustachian tube is the rule, and

there is no ventilation. Head kept as high as possible at night and vasoconstrictor medication orally and locally are of paramount importance in children with upper respiratory infections, especially if there is a history of recurrent ear involvement.[10]

Placement of a ventilating tube is the rational treatment for serous otitis media. We prefer the button-like Shephard tube which has a steel wire attached to one edge. It is safer, and in our experience, it has been extruded in a lower percent of cases and has given very few complications.

Myringotomy alone may be adequate in a few cases, but it has been well demonstrated that ventilation of the cavity through a tube is necessary until there is restoration of normal function of the eustachian tube.[4] With a simple myringotomy, the incision of the drum is closed in one or two days, or sooner. If the fluid has been evacuated but impairment of function of the tube and negative pressures persist, the effusion will reappear. The tube needs to be left in place for a period of from four to ten months. With the exception of swimming, the child can continue all normal activity without problems. However, the tube could become extruded causing the drum to close. The tube should be replaced if hearing is not reestablished and there is insufficient function of the eustachian tube. The operation is a mild one that requires only one day of hospitalization, or none. However, it is recommended that the operation be done under general anesthesia and microscope.

Summary

Early diagnosis of serous otitis media in children is important to prevent permanent loss of hearing. Deafness is established insidiously and often without any other sign.

Conductive loss of 25 decibels in children delays speech development. Prolonged negative pressure causes irreversible changes in the ear.

Insufficient antibiotic treatment is a known cause of serous otitis media; allergy, mechanical obstruction with adenoids, and viral infections are also significant causes.

Ten days of antibiotic treatment with adequate concentration in the blood at all times is recommended in all upper respiratory infections with ear involvement.

Delay of tonsillectomy and adenoidectomy when the ear is involved contributes to establishment of ear effusion.

Insertion of a ventilating tube is the rational treatment.

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THE ART OF SURGERY FOR DEAFNESS has reached a level of sophistication yielding generally good results. The selection of patients for surgery is most important and is guided by otologic examination with magnification, auditory and vestibular testing, and radiologic studies. Surgery is performed with the aid of magnification and an armamentarium of delicate instruments. Postsurgical complications such as aggravation of the deafness and facial-nerve injury are rare. Yet there are many types of pathologic change in the sound-transmission system, such as eustachian-tube blockage, severe middle-ear scarring and round-window otosclerosis, to mention a few, that are not amenable to surgical correction.

The field of otologic surgery for deafness is still young. It is inevitable that experience and research will produce refinements in technic and a broader application of surgery for deafness.—Harold F. Schuknecht, M.D., and Edward L. Applebaum, M.D., Boston: *The New England Journal of Medicine,* 280: 1154-1160, May 22, 1969.

with negative blood cultures. The latter may represent instances of sterile endocarditis, or infections caused by organisms such as bacteroides, listeria, or microaerophilic streptococci which require specialized cultivation.

The changes in organisms are attributed to antibiotic usage, long term hospitalization, aging patient populations, and aggressive surgical manipulation.

Clinical Manifestations

Textbook descriptions include fever, heart murmur, splenomegaly, anemia, and some manifestations of peripheral embolization. The majority of patients do not manifest this clear-cut picture. A recent series revealed that 75 percent of patients with endocarditis had no evidence of peripheral embolization, 60 percent had no splenomegaly, and 4 percent had no heart murmur.

Murmurs of endocarditis are generally insufficiency murmurs. Flow murmurs in patients with fever and enemia are often considered as evidence for endocarditis, but frequently these findings merely represent a hyperdynamic circulation. Rapidly changing murmurs are rarely evidence of endocarditis unless there has been rupture of chordae tendinae or papillary muscles, or heart failure. Changes in cardiac function alone characteristically produce changing cardiac murmurs. An infrequent cause of change in cardiac function is endocarditis. However, sudden onset of myocardial infarction or congestive heart failure in a patient with previously compensated congenital or rheumatic heart disease may be the presenting finding.

Fever, the most common physical finding, may be absent for a variety of reasons including treatment with aspirin, shock, advanced age, antibiotic treatment, uremia, steroid treatment, or severe infection.

Endocarditis may present as an acute fulminating illiness in which meningitis, intracerebral hemorrhage, congestive heart failure, cardiac arrhythmia, or uremia are prominent, and the underlying cause is overlooked. Neurologic manifestations are particularly common in the elderly and in patients with cyanotic congenital heart disease. In such persons, signs of brain abscess, toxic psychosis, or meningitis may be the initial event. On occasion, peripheral embolization may be a presenting form with such manifestations as infarction of fingers, toes, nose, or ear lobes. Embolization of larger blood vessels suggests fungal or *S. aureus* endocarditis; a common site of infarction is the spleen. Splenomegaly is often absent at the onset, although patients may complain of a left upper quadrant abdominal pain. Both renal embolization and glomerulitis—the latter probably autoimmune in origin—are common in cases untreated for some time. Hematuria, proteinuria, and azotemia resulting from this type of involvement may lead to an initial diagnosis of glomerulonephritis or renal failure. The anemia is nonspecific and is present in approximately two thirds of the cases. It is usually normochromic, normocytic and may be associated with monocytosis.

Treatment

Antibiotics either singly or in combination should be chosen for bactericidal activity against the infecting organisms. Ideally, the antibiotic should have a sufficiently low order of toxicity to permit an appropriate duration of treatment. We feel that the minimum time is three weeks. Some authors have presented good treatment results of *S. viridans* endocarditis with large doses of penicillin and streptomycin in two weeks. Tube dilutions to determine bactericidal endpoint of antibiotics on the patient's organism, and the bactericidal effects of his serum upon his organism, are helpful in guiding therapy. A bactericidal blood level, five times greater than the minimum in vitro bactericidal level, is generally sought.

When blood cultures are negative or when treatment has been started before appropriate cultures have been obtained, treatment may be carried out with large doses of penicillin (12 to 20 million units a day) and streptomycin (250 mg. every six hours) for at least four weeks.

Antibiotic therapy will not improve the damaged valve, and distortion of valve function may follow healing and scarring; surgical correction may ultimately be needed. In cases of severe valvular disease and cardiac decompensation, valvuloplasty may be required. Cardiac surgery in the face of infection may be necessary. This should not be undertaken lightly, but it may be the only recourse if infection is uncontrolled or heart failure due to valve damage is not controllable by medical therapy.



Research Protocol

The Common Seborrheic Wart as a Test Model for Studying Factors of Controlled Tissue Growth

For a number of years the Department of Dermatology has studied the common seborrheic warty growth. The basic phases of the work have included an analysis of clinical types of these lesions and the dynamic morphologic structure as shown in histopathology, histochemistry, scanning electron microscopy, and transmission electron microscopy. These studies have shown the detailed characteristics of this common warty spot which all of us get eventually. These morphologic studies have shown also that at superficial glance, without special diagnostic technics, these benign lesions can simulate important growths like melanoma, especially, and epitheliomas of the skin. The special diagnostic technics include skin microscopy with photography of the skin at moderate magnification, replica microscopy, and scanning electron microscopy. The purpose of recognition of the early lesion is to secure adequate therapy to prevent recurrences and to prevent disfigurement from attempts to treat the late and progressive types of lesions.

The next phase of the work has been an attempt to study some of the parameters of controlled tissue growth. This growth rarely becomes cancerized, if ever. Most of the confusion results from failure to observe the progressive spread of adjacent malignant skin tumors into this benign growth. However, Dr. Arthur Hyman, New York Skin and Cancer Hospital, has observed several examples of cancerization. In our series of many hundreds of patients, only two patients have been found whose biopsies showed also cellular dysplasia. In these patients, actinic exposure was suspected. The types of irritation studied have been mechanical, actinic, and irradiation with various modalities, including x-ray, Grenz, laser, and ultraviolet. Solar exposure is of interest because of the distribution patterns of these growths on the hands and extremities, not on the trunk. The lack of effect of the cytotoxic agents, such as 5-FU, even though acanthosis is a prominent feature, is of interest and still under study.

Another phase of the investigation has been an attempt to look for any immunologic aspects. Detailed electron microscopy studies have shown no viral organisms. Preliminary studies of inoculation have been negative. Injections of extracts in incomplete Freund adjuvant have not shown any results with regard to prevention of new growths. Present meager studies of immunofluorescent technics have been negative. Exchange transplants have retained the identity of the skin transplanted. Important work remains to be done on tissue cultures and genetic studies since this warty growth is an autosomal dominant. The significance of the genetic studies is that those families who have early development of these spots should have early treatment to avoid need for treatments of larger lesions.

Another phase of the problem has been the development of an effective treatment program. This includes studies of frequency of the recurrences associated with different modalities of treatment, especially after excision and incomplete coagulation necrosis. The treatment must be vigorous and extend into the dermis. The mechanism of the dermal factor in this common lesion is not understood. Efforts are made to try to study morphologically the appendages in the development of recurrent lesions. In some experiments, ultraviolet, laser, and even x-ray have been delivered only to the dermis in areas of widespread growths. Treatment modalities include high-frequency electrosurgery, cryosurgery, excisional surgery and curettments, and investigative laser surgery. Excisional surgery may be used on the face; excisional surgery of the back is followed often by broad, ugly scars. Investigative laser surgery has shown significant results in smaller lesions. More studies

Submitted June 11, 1970

are needed to determine the effects of the laser in this treatment program. The proper evaluation of an effective treatment program can be done after some years of observation of individual lesions.

Summary

This common lesion, then, offers itself as a test model for an attempt to understand the factors between controlled tissue growth and uncontrolled tissue growth which leads to malignancy. The research program includes as a control for an uncontrolled growth, the common precancerous actinic keratosis. These two, then, are models of the reactions of man to growth stimuli in an easily available tissue of man.—Leon Goldman, Professor and Chairman, Department of Dermatology, and Director, Laser Laboratory, University of Cincinnati Medical Center, Cincinnati.

Self-Evaluation Quiz

1. The diagnosis of acute fetal distress is most strongly indicated by which of the following signs:
   (A) Fetal tachycardia of 160 beats per minute or greater
   (B) Vaginal passage of meconium
   (C) Fetal scalp blood pH 7.15
   (D) Variable decelerations of fetal heart rate which drop to less than 60 beats per minute
   (E) Decreased amplitude and frequency of fetal heart rate beat to beat irregularities.

[*From the Department of Obstetrics and Gynecology, University of Cincinnati College of Medicine. The answer is given on p. 1134 of this issue. —Ed.*]

2. In treatment of maternal hypotension associated with spinal anesthesia administered for obstetric delivery, which pharmacologic agent will most likely produce improvement of uterine blood flow in addition to peripheral vasoconstriction?
   (A) Levarterenol (Levophed)
   (B) Metaraminol (Aramine)
   (C) Phenylephrine (Neo-Synephrine)
   (D) Angiotensin amine (Hypertensin)
   (E) Methoxamine hydrochloride (Vasoxyl)

[*From the Department of Obstetrics and Gynecology, University of Cincinnati College of Medicine. The answer is given on p. 1134 of this issue. —Ed.*]

3. In the differential diagnosis of feminine hirsutism and infertility, which of the following laboratory determinations constitutes the best evidence for congenital adrenal hyperplasia?
   (A) Urinary 17-ketosteroids
   (B) Urinary pregnanetriol
   (C) Urinary estriol
   (D) Serum melatonin
   (E) Serum 21-Hydroxylase activity

[*From the Department of Obstetrics and Gynecology, University of Cincinnati College of Medicine. The answer is given on p. 1134 of this issue. —Ed.*]

Most Physicians Give Dedicated Service Under Care Programs, AMA President Declares

THE PRESIDENT OF the American Medical Association in a recent public address charged the federal government and press with carelessly discrediting many dedicated doctors.

Dr. Walter C. Bornemeier said there were "numerous cases" of the government unjustly accusing physicians of abusing the Medicare and Medicaid programs—but not naming names.

In the press, he said, there have been "a continuing string of articles . . . implying that physicians who treat the poor are either stealing from their patients, cheating the government, or both."

Pointing Out the Accused

The AMA head then called upon the government to "give us the names of doctors suspected of abusing the program, so our county society peer review committees can investigate."

He said these committees had already investigated a number of cases "and appropriate measures are being taken."

But he pointed out that to date, medical investigations had shown the percentage of actual abuses "was very small."

Dr. Bornemeier said that the nation's medical and health care system "is not riddled with graft or festering with incompetence."

It is, he said, "made up of men and women who are proud of their skills and dedicated to using them for the betterment of their fellowman."

Then, Dr. Bornemeier charged:

"It was the federal government—not our profession—that insisted on paying for the poor.

"Yet today, physicians all over the country are being accused of fraud and worse things because they are accepting government money for taking care of people under those laws.

"Many physicians devote all or most of their practice to the care of the poor. And we are grateful to these dedicated doctors."

He said that "under the federal laws which the government passed," many physicians are "receiving a substantial amount of federal payment." But he added:

"The assumption by some is that any physician who is being paid more than a certain amount of money through the program is automatically guilty of a dark and criminal act.

"It makes no sense to me at all to pass a law saying you will pay a professional for what he has been doing free—or persuade a physician to establish himself in an undersupplied area—and then accuse him of wrongdoing because payments are made for his service."

Going Off Half Cocked

Dr. Bornemeier, speaking in Boston before the Association of Life Insurance Medical Directors of America's 79th annual meeting, cited the following case of the government's inaccuracy. He said:

"Recently the Senate Finance Committee Staff Report released a lot of figures that indicated abuse (of the Medicare and Medicaid programs by doctors).

"They would not give us names but we got some of them by cross-reference.

"Two instances in Colorado where a doctor was accused of getting several hundred thousand dollars were found to be the total amount of an entire hospital staff group practice.

"All bills were sent by the medical director—who was then the accused. There were numerous similar cases. Actually the percentages of abuses was very small."

The doctor admitted that "we do have a few rascals in the profession." He explained:

"Some doctors have over-utilized the program. This has been done chiefly out of the hospital. In the hospital, it is easy to spot abuse. Out of the hospital, it is not easy."

Dr. Bornemeier said he wanted to leave the audience with "one major impression." That is: "Our medical and health care system in this nation is a good one." He added:

"It has not broken down. It is not falling apart. It has made mistakes. It still has its faults, but it is moving rapidly. It is getting well."

The American Society for Clinical Pharmacology and Therapeutics will hold its 72nd annual meeting in Atlantic City, N. J. April 29-May 1. Persons interested in presenting papers are invited to contact Leo E. Hollister, M.D., American Society for Clinical Pharmacology and Therapeutics, 1718 Gallagher Road, Norristown, Pa. 19401.



Professional Activities

Proceedings of The Council

Meeting of September 19-20, 1970

A REGULAR MEETING of the Council of the Ohio State Medical Association was held Saturday and Sunday, September 19 and September 20, 1970 at the headquarters office, 17 South High Street, Columbus, Ohio.

Those present on Saturday, September 19, were: All members of the Council; Mr. Wayne E. Stichter, Toledo, OSMA legal counsel; Mr. James S. Imboden, Columbus, AMA Field Representative; Drs. Philip B. Hardymon, Columbus, Harry K. Hines, Cincinnati, Theodore L. Light, Dayton, Carl A. Lincke, Carrollton, Frederick P. Osgood, Toledo, delegates to the American Medical Association, Drs. Henry A. Crawford, Cleveland, Robert E. Howard, Cincinnati, W. J. Lewis, Jr., Dayton, Robert S. Martin, Zanesville, L. C. Meredith, Oberlin, alternate delegates to the AMA; and Messrs. Page, Edgar, Gillen, Campbell, Clinger and Moore of the OSMA staff. Present by invitation were: Dr. Emmett W. Arnold, Columbus, Director of the Ohio Department of Health; Messrs. William A. Lukeman, Philip Mika, Bernard D. King and William S. Rothermel, Jr., representing the Student American Medical Association.

Those present on Sunday, September 20, were: All members of the Council; Mr. Stichter; Drs. Osgood and Crawford; Dr. Anthony Ruppersberg, Jr., Columbus, chairman of the OSMA Committee on Maternal Health, present by invitation; and Messrs. Page, Edgar, Gillen, Campbell, Clinger, and Moore of the OSMA staff.

Minutes Approved

Minutes of the meetings held July 18 and 19, 1970 were approved by official action.

Reports by Councilors

The Councilors reported on organizational activities in their respective districts.

Membership

Statistics

The Executive Director reported a total membership of 10,098 as of September 18, 1970 as compared with a total membership of 10,158 on September 18, 1969. Of the 10,098 OSMA members, 8,601 were affiliated with the American Medical Association.

Policy on Dues for 1971

The policy on dues for 1971, under the authority of Section 1, Chapter 2 of the OSMA Bylaws, was promulgated by the Council with the following regulations governing dues for mem-

bership categories other than associate, active and honorary, these three being subject to the determination of the House of Delegates:

1. **Resident and Intern Members** — By official action of the Council, annual Ohio State Medical Association dues during 1971 for resident and intern members shall be $5.00. Such intern or resident member shall be entitled to receive *The Ohio State Medical Journal* as a part of his membership privileges.

2. **Non-resident Membership** — The Council determined that dues for non-resident membership shall be $25.00.

3. **Members on Temporary Military Service** — State Association dues during 1971 shall be waived for members on temporary military service and not making military medicine a career. State Association dues for 1971 shall be waived for physicians who were members of the Association in 1970 and who enter such services during the calendar year 1971 before the payment of 1971 dues. A refund of membership dues will not be made if a member enters such services in 1971 after his 1971 dues are received at the Columbus office of the Association. The secretary-treasurer of each county medical society shall be requested to cooperate with the Columbus office in assembling the names of physicians entitled to waiver of dues under the foregoing provisions.

Policy on Prorating of Dues for 1971

By official action, the Council **adopted** the following policy on prorating of annual dues for the calendar year 1971:

That dues for new associate and active members in practice, affiliated with the OSMA during the last six months of the calendar year 1971, namely, July 1 to December 31, inclusive, shall be $25.00, one-half the regular per capita dues of $50.00. The prorating of dues shall not apply to former members reaffiliating as associate and active members.

Amendments to Bylaws

Geauga County

Amendments to the bylaws of the Geauga County Medical Society, which would provide for a president-elect instead of a vice-president and which would change a quorum for doing business, **were approved** by the Council, subject to technical amendments suggested by the legal counsel.

Model Constitution and Bylaws for County Medical Societies

The Council approved a communication to be sent to all county medical societies concerning changes necessary to bring county bylaws into conformity with the 1970 revision of the OSMA bylaws.

The OSMA legal counsel submitted technical amendments to bring the "model" county medical society bylaws into conformity with the 1970 revisions of the Ohio State Medical Association Constitution and Bylaws. These **were approved** for transmittal to county medical societies.

Federal Legislation

Report on S.B. 4297

Mr. Edgar reported on S.B. 4297, the bill to establish a national socialized medicine system. U.S. Senator William B. Saxbe, Ohio, is one of the four primary sponsors of the bill, which was introduced August 27, 1970.

Mr. Edgar reported that, while hearings on the bill will be conducted by Senator Yarborough before the Senate Labor Committee this year, serious hearings will be conducted before the Senate Finance Committee in 1971.

State Legislation

Pharmacy Board Amendments

Mr. Edgar reported that the Committee on Public Relations had studied the proposed amendments to the state pharmacy act with the assistance of the OSMA legislative counsel.

The Council expressed itself as having no objections to the amendments in their present form and is reserving ultimate judgment until the legislature has submitted the bill in its final form.

Medical Treatment of Minors

The Council reviewed a communication from Dr. Thomas E. Shaffer, Columbus, with regard to the establishment of policies for the medical treatment of minors. The communication was referred to the Committee on School Health for implementation with review by the Judicial and Professional Relations Committee.

Chiropractic

The Council referred Resolution No. 4-70 on chiropractic, adopted by the 1970 Ohio State Medical Association House of Delegates, to the OSMA staff and legal counsel.

It was the opinion of the Council that the drawing of blood for diagnostic purposes and the use of X-rays for diagnostic purposes are not within the scope of chiropractic.

Report of Ohio Director of Health

Dr. Emmett W. Arnold, Ohio Director of Health, presented his annual report to the Council.

Director Arnold's introductory remarks were an expression of appreciation to the Ohio State Medical Association for the opportunity over the years to meet with the Association's officers and staff. Dr. Arnold commended the Council on its conscientious approach to the problems of medicine and public health. An article on this report to the Council appears on page 1074 of *The Journal.*

Ohio Medical Indemnity, Inc.

Report of Liaison Committee

Dr. Robert M. Smith, chairman of the Liaison Committee, presented his report.

Fee Review Cases

A report on OMI cases was presented by Mr. Campbell as follows: Cases referred to the Ohio State Medical Association, 18; three were usual and customary; ten were reduced; four were pending; and one miscellaneous case was settled satisfactorily without specific county medical society recommendation.

Workmen's Compensation

Fee Review Cases

Mr. Campbell reported on fee review with regard to Workmen's Compensation cases. Total number of cases referred to the Ohio State Medical Association, 190; 98 were usual and customary; 56 were reduced; 2 were pending; and there were 34 miscellaneous cases settled satisfactorily without specific county medical society recommendation.

Medical Department of OBWC

A letter from Dr. O. L. Coddington, Medical Administrator for the Ohio Bureau of Workmen's Compensation, was presented by Mr. Campbell. This communication suggested legislation to raise the salaries of physicians in the medical section in order to make it possible to overcome shortages in this category. It was the expression of the Council that if such legislation is introduced it will be actively supported by the Ohio State Medical Association.

Physicians in Osteopathic Hospitals

The Council received communications from the Montgomery County Medical Society and the Academy of Medicine of Cleveland with regard to physicians serving in osteopathic hospitals.

The Council reaffirmed its action of July 18-19, 1970, stating that there is no objection to physicians serving in osteopathic hospitals, providing the members of the staff of the osteopathic hospital practice scientific medicine and abide by ethical principles equivalent to the *Principles of Medical Ethics* of the American Medical Association.

New York Abortion Law

With regard to a communication from a member as to whether it is legal for an Ohio physician to refer a patient to an agency in New York providing counseling on abortion, the Council felt that such procedure is legal. However, the Council warned about communicating any medical information to such agency without the written consent of the patient and, if the patient is a minor, without the written consent of the parents as well. It was felt that it would be advisable for the physician to address the communication to the patient, covering the necessary findings which the patient may transmit to the agency at his own discretion.

Use of Term "Clinic"

The Council received a communication with regard to the ethics of a four-man general practice group, currently undergoing incorporation, choosing a title, "(Location) General Practice Clinic." The Council expressed itself as having no objection to the use of the word "clinic" in this manner. The Council advised the physicians involved, however, that since they are being incorporated they should check with an attorney about the proper term to be used to indicate that the clinic is an incorporated organization.

Student AMA

Messrs. William A. Lukeman, Philip Mika, Bernard D. King and William S. Rothermel, Jr. appeared before Council with regard to the activities of the Student American Medical Association.

Mr. Lukeman addressed the Council. (A copy of his remarks appear on page 1135 of *The Journal.)*

At the conclusion of the meeting the Council voted to invite student AMA representatives to sit in on OSMA committee meetings, at the discretion of the President of the Ohio State Medical Association.

The Council instructed the President of the Association to write to the presidents of the medical societies in counties where colleges of medicine are located in Ohio, advising them of the action of the Ohio State Medical Association and urging that similar action be taken in these coun-

ties, permitting student AMA representatives to attend meetings of the societies' committees.

AMA Delegation

Mr. Gillen presented the minutes of the September 18 meeting of Ohio's AMA delegation. The minutes **were approved** by the Council.

Among the actions **approved** was the selection of Dr. Philip B. Hardymon, Columbus, to serve as chairman of the delegation until the end of the current calendar year.

The annual meeting of the delegation was changed from September to the first Council meeting after January 1, each year.

Dr. Henry A. Crawford, Cleveland, was selected to be seated as a delegate at the Boston meeting in place of Dr. Budd, resigned. Dr. Frederick P. Osgood was named to serve as chairman of the Committee on Resolutions; Dr. Harry K. Hines, Cincinnati, chairman of the Committee on Hospitality and Dr. Robert E. Tschantz, Canton, chairman of the Committee on Candidates.

Committee Reports

Eye Care

Mr. Clinger presented the minutes of the April 26 meeting of the Committee on Eye Care. The Council voted in this connection to actively support a proposed bill to register and regulate the practice of optical dispensing in Ohio, with two changes in the draft which was originally presented.

Education

Mr. Edgar presented the minutes of a meeting of the Commission on Medical Education held July 1, 1970.

The Council voted to invite Dr. Glidden L. Brooks, Toledo, and Dr. Barry Decker, Cleveland, to the next meeting of the Council to explain and interpret the report of the Subcommittee on Evaluation.

Hospital Relations

Mr. Gillen presented the minutes of the July 29 meeting of the officers of the Ohio Hospital Association and the Ohio State Medical Association. The minutes **were approved,** including a provision for a permanent mechanism on an advisory consultative basis to assist in solving disputes between physicians and hospitals.

The Council **approved** a recommendation that an effort be made on a staff level to work on the wording of the hospital licensing bill to keep medical services out of the bill, inasmuch as the medical profession is already regulated by the Ohio Medical Practice Act.

Included in the recommendation **approved** by the Council was a recommendation that the Ohio Public Health Council study the matter of changing the maternity hospital licensing regulations with regard to a "formula room," since the widespread use of packaged formula for infant feedings eliminates the necessity for a separate formula room.

Membership and Planning

Dr. Schultz presented the minutes of the August 5 and September 18 meetings of the Committee on Membership and Planning. The Council **approved** the minutes and such approval included a provision for another survey of the Ohio State Medical Association membership on January 15, 1971.

Environmental and Public Health

Mr. Gillen presented the minutes of a meeting of the Committee on Environmental and Public Health held August 12, 1970. The Council **approved** the minutes, including the request for a time change in the annual meeting general session on "Medicine and the Environment" by changing it from Tuesday morning to Tuesday afternoon on May 11, 1971. It was the expression of the Council that the public should be invited to this general session.

Nurses

The minutes of the August 19 joint meeting of representatives of the Ohio Nurses Association and the Ohio State Medical Association were presented by Mr. Gillen and were accepted for information.

Sports Medicine

A report on the September 2 meeting of the Joint Advisory Committee on Sports Medicine was presented by Mr. Clinger. Such minutes included recommendations, previously **approved** by mail, to endorse a proposal for certification standards for coaches of interscholastic athletics.

Health Care

Dr. Howard presented the minutes of the September 9 meeting of the Ad Hoc Committee on the Delivery of Health Care. The minutes **were approved** as presented.

Laboratory Medicine

Minutes of the meeting of the Committee on Laboratory Medicine held September 9, 1970 were presented by Mr. Campbell. The minutes **were approved** as presented.

Included in the minutes was a recommendation that a series of requirements established by



CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.



Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives.There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*: 267-279 (May) 1967. *2.* Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. *3.* Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. *4.* Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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the Ohio Department of Public Welfare for professional associations be deleted on the basis that it is unnecessary and inappropriate.

Recommendations concerning the Proficiency Evaluation Program, OSMA House of Delegates Resolution No. 24-70, reiteration of a long standing policy against licensing of medical technologists, a policy with regard to laboratory licensing legislation, and suggestions for amendments to S.B. 234, the autopsy bill adopted by the 108th Ohio General Assembly **were approved** by the Council. For a report on the Proficiency Evaluation Program see page 1097 of *The Journal.*

Insurance

Minutes of the September 13 meeting of the Committee on Insurance were presented by Mr. Campbell. The Council **approved** the recommendations of the committee, which included a proposal for legislation on "informed consent" to be submitted to the 109th Ohio General Assembly.

The Council also **approved** the establishment of a life insurance trust for medical corporations as suggested by Turner and Shepard, Inc. and asked that the trust instrument be approved by the OSMA legal counsel.

Fee Review

Minutes of the meeting of the Fee Review Committee held September 16, 1970 were presented by Dr. Ivins. Action of the Fee Review Committee with regard to cases under consideration **was approved** by the Council.

The Council instructed the President to address a communication to the Mahoning, Stark and Summit County Medical Societies asking for fee review upon request of any third party. The Council directed that appropriate Citations from the AMA Judicial Council Opinions and Reports accompany these communications.

Maternal Health

Dr. Ruppersberg presented the 1967 annual report of the Committee on Maternal Health. The report **was approved** for publication in *The Ohio State Medical Journal.*

MECO Program

The Council voted to give administrative support to the 1971 Medical Education and Community Orientation Program sponsored by the Student American Medical Association.

OSMA Golf Association

With regard to a request for staffing the OSMA Golf Association, it was suggested that selected county medical society executives be asked by the golf association for assistance and, if such is not available, to return the matter to the Council.

Reports on Grievance Cases, Malpractice Suits and Public Welfare Cases

Summary reports were presented on grievance cases referred to county medical societies by the

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Council, malpractice suits appearing in the news media, and cases sent to the Council by the Ohio Department of Public Welfare.

Community Health Record System

A communication from the Battelle Memorial Institute, Columbus, with regard to a proposed community health record system was discussed and then referred to the Judicial and Professional Relations Committee.

Great Lakes Waterway Pollution

The Council received a report from Dr. Roland L. Kennedy, Toledo, Ohio State Medical Association delegate to a meeting on pollution of the Great Lakes Waterway which was held in Toronto, Canada.

Commendation to Dr. Cromartie

The Executive Director presented to the Council a letter received from Col. Robert M. Chiaramonte, Superintendent of the Ohio Highway Patrol, reporting that Junius Cromartie, M.D. had been awarded an honorary commission by the Ohio Highway Patrol for his outstanding service to and care for Highway Patrolman Gerald D. Riley. The Council voted to congratulate Dr. Cromartie and to commend him for a service to medicine and to the public.

Retirement of Florence W. Okert

The Executive Director announced the proposed retirement of Miss Florence W. Okert, scheduled for on or about December 31, 1970, subject to the approval of the Pension Committee.

Mr. Page advised the Council that a study of the possibilities of computer billing and membership records will be made to see if such services are adaptable to the OSMA operation.

Best Wishes to Charles F. Price

The Council expressed its best wishes to Charles F. Price, Director of the Department of Economic Research, for a speedy recovery from his illness.

Date of Next Meeting

The tentative date for the next meeting of the Council will be November 14-15, 1970 in the headquarters office, Columbus.

ATTEST: Hart F. Page
Executive Director

Answers to Self-Evaluation Quiz

Page 1123 Question 1. (D)

References: Hon EH: *An Atlas of Fetal Heart Rate Patterns.* Harty Press, Inc., New Haven, Conn., 1968, p. 283.

Wood C, et al: Fetal heart rate and acid base status in the assessment of fetal hypoxia. *Amer J Obstet Gynec* 98:62, 1967.

Mendez-Bauer C, et al: Relationship between blood pH and heart rate in the human fetus during labor. *Amer J Obstet Gynec* 97:530, 1967.

Page 1123 Question 2. (B)

References: Shnider SM, et al: Vasopressors in obstetrics. *Amer J Obstet Gynec* 102:911, 1968.

Greiss FC: A clinical concept of uterine blood flow during pregnancy. *Obstet Gynec* 30:595, 1967.

Boba A, Linkie DM, Plotz EJ: Effects of vasopressor administration and fluid replacement on fetal bradycardia and hypoxia induced by maternal hemorrhage. *Obstet Gynec* 27:408, 1966.

Page 1123 Question 3. (B)

References: Mahesh and Greenblatt: Investigation of the Hirsute or Virilized Female" in *Advances in Obstetrics and Gynecology,* vol 1, Williams & Wilkins, Baltimore, 1967, p. 374.

A Medical Student Addresses the Ohio Medical Profession

AT THE INVITATION of the OSMA President, Ohio representatives of the Student American Medical Association appeared before The Council of the Ohio State Medical Association at its meeting September 19-20 to present a petition. Following is the text of the petition presented by William A. Lukeman, third-year medical student and vice-president of the Ohio State University Chapter of the Student AMA. For the Council's response, refer to page 1127.

* * *

Mr. President and Other Distinguished Members of The Council:

I want to begin by thanking you, in behalf of all the medical students, for giving us this special opportunity to talk with you. We know your time is unusually precious this weekend, and we appreciate your magnanimity.

As you know, we medical students are here today to speak in support of our request that "student representatives be granted the privilege of attending all OSMA committee meetings at the state level, except those meetings concerned with peer review, subject to the discretion of the committee chairmen." We are here because we believe you deserve to know the rationale behind our request before you make a decision on it.

We see this request as part of the solution to one of our biggest problems. The problem is that we have the "Ivory Tower Syndrome." This is the syndrome we acquire in medical school. It is the "disease" which we get from being constantly exposed to the world of the "Ivory Tower," where specialists and subspecialists alike impart factual knowledge, ethics, attitudes and values to us. Our education is loaded with subtle and overt cues encouraging us to become physicians in the mold of our teachers. It is incessantly implied in our education that the real challenge in medicine is identifying and curing the one case in a thousand, or doing the complex procedure that requires a fleet of assistants, diagnostic tests, and equipment. We also hear every day that promotion, peer approval, and prestige in academic medicine come from research and publication, and not necessarily from treating patients.

So what happens to us? We come to "understand" that the only good work is performed at hospitals affiliated with medical schools. And we are drawn into research—into the "publish-or-perish syndrome."

Yet many of us are waking up to the fact that in hundreds of communities all over Ohio there are highly intelligent and competent men like yourselves—men with vast experience and knowledge—from whom we could learn plenty, if we only had the chance. You are skilled in patient care: you have the technical skills, knowledge, and compassion required to treat individuals.

And you have much more, because you also have considerable experience in organized medicine. You know your way around Ohio's huge and complex medical monolith. You know something about getting the problems of medical care and health care delivery solved.

What I am saying, gentlemen, is that we need your help. We need instruction from you about the technical aspects of medicine. We need you to teach us that the real challenge in medicine is out there in your communities helping sick people to get better.

And we need to learn what organized medicine on the local, state and national levels is all about. We know that the spectre of government-controlled medicine hangs forebodingly over our heads like a dark storm cloud. And we know that there are hundreds of other problems which organized medicine must solve if medicine in this country is to excel. We also know we will be better prepared to help you solve the problems if we can soon learn about how organized medicine functions at the state level. That's why we are requesting the invitation to your committee meetings: we have much to learn in preparation for tomorrow.

Contrary to what some physicians say, this is not part of an insidious plan to "take over" organized medicine. There is no such plan. At this stage in our education, it would be presumptuous of us, indeed, to think that we could even begin to fill your shoes. We only want the opportunity to sit in your meetings—to listen and to learn.

Gentlemen, this is a plea. We are asking you to become our teachers—to instruct us as a father does his son, or an older brother does his younger brother. We believe that herein lies medicine's hope for the future. To put it as Geoffrey Chaucer did so long ago: "We are glad to lerne, are you glad to teche?"

REPORT ON EXAMINATION OF FINANCIAL STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 1969

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1969 and the related statement of operations and net worth for the year then ended. Our examination was made in accordance with generally accepted auditing standards and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of Ohio State Medical Association at December 31, 1969 and the results of its operations for the year then ended. in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Lybrand, Ross Bros. & Montgomery

Columbus, Ohio
April 4, 1970

OHIO STATE MEDICAL ASSOCIATION
Balance Sheet, December 31, 1969

ASSETS

Current assets:		
Cash, including time deposits of $191,284.02		$202,120.86
5% Certificates of deposit		30,000.00
Accounts receivable, less allowance for doubtful accounts of $49.42		10,876.19
Accrued interest receivable		800.00
Prepaid expenses and unamortized costs		52,453.64
Total current assets		296,250.69
Other assets:		
Investments:		
United States Government securities, at cost which approximates market	$ 45,000.00	
Ohio Medical Indemnity, Inc., at cost	56,000.00	
Deposits	675.00	
Unamortized pension costs, net of current portion (Note 2)	300,300.00	
		401,975.00
Furniture and fixtures, at cost (Note 1)	65,945.40	
Less accumulated depreciation	(24,955.49)	
		40,989.91
Total assets		$739,215.60

LIABILITIES AND NET WORTH

Current liabilities:	
Accounts payable	$ 31,645.56
Deferred membership dues	99,815.00
Other deferred income	9,541.50
Total current liabilities	141,002.06
Net worth	598,213.54
Total liabilities and net worth	$739,215.60

(The accompanying notes are an integral part of the financial statements.)

OHIO STATE MEDICAL ASSOCIATION
STATEMENT OF OPERATIONS AND NET WORTH

for the year ended December 31, 1969

Income:		
Membership dues		$472,782.50
Exhibit fees		30,315.00
Annual meeting		6,800.00
Fees for collection of AMA dues		5,502.70
Interest on savings accounts and certificates of deposit		13,559.34
Interest on United States Government obligations		1,544.00
Other		25.31
		530,528.85
Operating expenses:		
Ohio State Medical Journal, net	$ 56,845.28	
Salaries	158,584.20	
Honorariums and expenses	40,414.52	
Professional conferences and scientific meetings	83,316.21	
Committee expenses	17,944.59	
Public relations	8,869.94	
Employee benefits, including pension costs of $43,300	75,868.68	
Contributions	15,001.10	
General operating expenses	111,483.80	
		568,328.32
Net loss		(37,799.47)
Net worth, beginning of year	427,113.01	
Add unamortized pension costs (Note 2)	208,900.00	
Restated		636,013.01
Net worth, end of year		$598,213.54

(The accompanying notes are an integral part of the financial statements.)

NOTES TO FINANCIAL STATEMENTS

1. The Association provides for depreciation over the estimated useful life of the assets on the straight-line and declining-balance methods. Depreciation charged to operations during 1969 amounted to $3,941.22.

2. During the year ended December 31, 1969, the Association converted certain deferred compensation arrangements to an amended retirement plan which heretofore was funded under life insurance arrangements on a pay-as-you-go basis. Because of the nature of the amended plan and the materiality of the amounts funded by direct contributions and transfers of assets from previous plans, costs are being accounted for in accordance with Accounting Research Bulletin #8. Pension fund assets at the date of adoption include $342,000 relating to prior service costs and $44,900 relating to future service. Such amounts will be amortized to operations at the rate of $34,200 per year for prior service and $9,100 per year for future service. Accordingly, $43,300 has been charged to operations for the year.

In conforming the Association's accounting with respect to the amended plan to fall within the guidelines established by Accounting Research Bulletin #8, it has been necessary to increase beginning net worth by $208,900.

The Association has filed a request for a determination letter from the Internal Revenue Service approving the amended plan as a qualified plan under Section 401(a) of the Internal Revenue Code.



Investment Prognosis

By Frank Van Holte, Columbus

THE MARKET apparently is firmly set on a new bull trend. Particularly encouraging to many observers is the high volume in this rising market. We have seen as much as 100 blocks of 10,000 or more shares traded in a single day on the Bid Board, which gives evidence of a return to the market of many fund and institutional buyers. The GM strike is dampening hopes for a strong last quarter of 1970, but it is believed that the strike is only delaying an upsurge to the forepart of 1971.

Simply stated, the long-term outlook for carefully selected common stocks is bright, despite inflation, international tensions and other factors which affect the broad economic projections. When we try to overcome the effects of inflation we could try several forms of investing. We could buy real estate, rare books, old coins, stamps, and perhaps works of art — all offer protection against inflation — if you are an expert in these matters. If you invest in common stocks of sound companies which have demonstrable prospects for growth in earnings, at least you will get the expert management of such companies included in the price of the stock.

Assuming that you would like something specific, I will suggest each month some common stocks that I believe should be purchased now. Do not expect me to recommend speculative issues. In fact, these stocks will carry the highest ratings by Standard & Poor and Moodys and they should be attractive to physicians building a retirement portfolio although I do believe we will see some good gains on a relatively short term. I can confidently recommend the following stocks:

Campbell Soup Company: Campbell is not only the largest manufacturer of canned soups and spaghetti, but it also is a leading factor in other foods. Expanding markets for convenience foods and the introduction of new products, such as pet foods, should bring long term gains. The Company has operations in Europe, Mexico, and Canada, and has almost 31,000 employees. The Company is financially sound and earnings for fiscal 1970-71 should moderately exceed the previous fiscal year. The $1.10 annual dividend should be maintained. This high-quality stock is a leader in a comparatively stable industry.

Sterling Drug Company: All physicians are familiar with this leading producer of ethical and proprietory drugs including such familiar names as "Bayer Aspirin" and "Phillips' Milk of Magnesia." The company also produces many well known household and toilet articles. This aggressive company should record growth in all of its divisions, and owning a share of this company should be rewarding. An annual dividend of 75 cents per share is currently being paid, but this dividend is incidental to the growth possibilities. This is a good solid company and dividends have been paid each year since 1902.

Kraftco Corp.: Here is another leader in the food industry. In fact, Kraftco is the world's largest processor and manufacturer of packaged foods, and it also manufactures a wide line of dairy products. Kraft, Sealtest, Philadelphia, and Miracle Whip are extremely well known brand names and are found in almost every basket at checkout counters. This company also has operations throughout the world and has over 47,000 employees. Earnings in 1970 should approach $2.90 per share and the earnings uptrend should continue in 1971. The current annual dividend is $1.70 per share. This is an excellent stock, and projections for continued appreciation are very favorable.

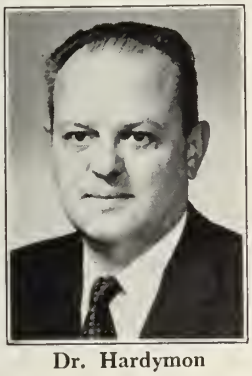
These three stocks should be added to the list of issues I have recommended in previous columns. You will observe that my selections are conservative and I am simply attempting to establish a shopping list for growth-minded investors. You should discuss these stocks with your broker or you can call me and I will be happy to give you additional information. I also suggest you consult with a broker before you sell securities because stocks should be sold with the same careful guidance utilized in buying.

This monthly feature is written exclusively for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Support Medical Education
Support Your AMA-ERF

OHIO'S ANNUAL CAMPAIGN on behalf of the American Medical Association Education and Research Foundation is now under way to make it possible for Medical Education Loan Guarantee Programs. Dr. Philip Hardymon, Columbus, is chairman of the Ohio AMA-ERF Committee, which is composed of the 11 District Councilors of the Ohio State Medical Association.

"Ohio can be proud of its 1969 AMA-ERF record with a total contribution figure of over $62,000. The Ohio State Medical Association's contribution ranks third, with Illinois and California in the lead," Dr. Hardymon said.



Dr. Hardymon

"Over half of the amount is contributed by the Woman's Auxiliary to the OSMA and we are proud to recognize them for the excellent work they have done in this regard." Following is an excerpt of a letter from the American Medical Association to the 1969 President of the Woman's Auxiliary Mrs. Samuel L. Meltzer.

> "John M. Chenault, M.D., President of the AMA-ERF, has asked this department to notify you that the Woman's Auxiliary to the Ohio State Medical Association has been given an Honorable Mention as the runner-up auxiliary in the category of the largest contribution to AMA-ERF for the 1969-70 National Auxiliary project for the American Medical Association Education and Research Foundation."

What more can be said. Thanks to the wives of our colleagues for a job well done.

We all know the importance of AMA-ERF and we wish to point out several points which indeed make this loan program unique and important to the furtherance of medicine.

1. A maximum loan period of 17 years.

2. No payments on principal to be made until the individual has been in practice for a period of six months.

3. A repayment plan that will allow a choice between level payments or accelerated payments.

4. Provision for large funds, nationally, for the life of the program.

5. A lower interest rate than normally provided for this type of loan.

6. Provides the borrower with a guaranteed rate he will be charged when he repays the loan, enabling him to know the total cost of his loan before he borrows.

In general, the program is similar at all levels of medical education, both graduate and undergraduate. Medical schools (and hospitals) make the details of this plan known to the students and provide application materials to students who need to borrow. Private banking institutions make the loans and the AMA-ERF guarantees the loan so that the interest cost to the student will be minimized.

The four medical schools in Ohio received a total of $36,190.44 from AMA-ERF in 1969 as follows:

Case Western Reserve University School of Medicine — $10,895.73

The University of Cincinnati College of Medicine — $13,586.87

Ohio State University College of Medicine — $11,430.34

The Medical College of Ohio at Toledo — $277.50

All of this has been done by the private sector of the economy without government subsidy. This is an enviable record which we hope to maintain.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardymon and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond generously in this year's campaign.


Gone with the wind

The gas/acid group of disorders

"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

Always in good taste

The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

Select the form of SILAIN-GEL you want to provide symptomatic relief in: gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity • gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select
Silain-Gel® Tablets:

when the patient prefers a liquid, select
Silain-Gel® Liquid

Also available for the patient who needs an antifrothicant/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

Announcing the "Antgasid"

Silain-Gel®

Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

one dose does both: frees captured gas...neutralizes free acid

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220

Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

2/8—After 11 days of treatment. Erythema is seen at site of keratoses. In addition, numerous lesions not apparent prior to therapy have become manifest as sharply defined reactions. Intervening skin also treated, shows no response to therapy.

3/1/69—One year after cessation of therapy. Skin appears clear with no evidence of scarring. Examination reveals absence of recurrence or the formation of new lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new
Efudex®
(fluorouracil)
cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning the site of application. Other local reactions included dermatiti scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scalin swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice da with a nonmetal applicator or suitable glove in an amount of t solution or cream sufficient to cover the lesion. When Efudex i applied to a lesion, a response occurs with the following sequer erythema, usually followed by vesiculation, erosion, ulceration necrosis and epithelization. The lower frequency and intensity activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammator reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of th lesion may not be evident for 1 to 2 months following cessation Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—contain 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methy and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions whe complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or mo was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 17 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

ROCHE
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LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Now's the Time to Gear Up for 1972 Campaign and Elections

PROBABLY BY THE TIME Ohio physicians have a chance to read this issue of *The Journal,* the 1970 General Election will have become history. A percentage of the members of the medical profession will be well satisfied with the election results; others will be disappointed.

Be that as it may, one thing is crystal clear: One election does not settle all issues for ever and anon. Politics is a full-time, year-round job which must be worked at with dedication and perseverance by those who want to see capable persons in governmental positions. It must be pursued by those who are willing to concede that some econonic and social changes are necessary to meet pressing modern problems of society, but who, at the same time, are willing to fight to keep shackles from being fastened on their profession or business . . . willing to battle to preserve individual rights.

Ohio physicians have not been indifferent to governmental and political activities. However, this is not to say that they have done enough. Too many of them have played the role of "let George do it." If ever there is a time for a change, it is now . . . **time to forget the 1970 election and to focus on the next time around . . . 1972.** That is when incumbents who have proved their competence can be returned to office . . . those who have disappointed their constituents can be retired to private life.

The Ohio Medical Political Action Committee is the "strong right arm" of the medical profession of Ohio in activities between now and the 1972 elections. It has operated effectively, for the most part, in the political field.

Its batting average in wins and losses among candidates supported is excellent. Its work has given a real punch to the legislative and governmental programs of the medical profession here in Ohio.

Occasionally, OMPAC has made a boner in helping to elect candidates who have gone sour after taking office. That's politics . . . that's the way the ball bounces . . . OMPAC has a long memory . . . **when the failures come up for re-election they'll find OMPAC aligned against them.**

To get to the major point of this message to the OSMA membership: Now is the time when OMPAC needs the help of individual physicians in building up its coffers for the 1972 political campaigns. Forget what happened or should have happened this year. **The time for additional contributing to OMPAC is when you pay your medical societies dues for 1971 . . . again in 1972.** Combined billing has proved to be the only really successful method of collecting OMPAC contributions.

Keep this in mind when you submit your check to your local medical society secretary-treasurer . . . Make it cover both medical society dues and $25 contribution to OMPAC. This is one way you can help make the influence of the medical profession felt in the political arena . . . a mass attack which far exceeds the effect which you as a single individual can make. Organized contributing and organized giving to the campaigns of worthy candidates carry a real wallop. Hope you'll join the team.

— *Ohio Medical Political Action Committee*

Dayton Physician Cited by Highway Patrol

Dr. Junius Cromartie, of Dayton, received national recognition when he was cited for outstanding care of an injured patrolman. Specifically, he was appointed an Honorary Member of the Ohio State Highway Patrol for his outstanding service to and care of Patrolman Gerald D. Riley.

Dr. Cromartie was pictured with the framed Honorary Membership in a recent issue of the *American Medical News,* weekly news publication of the American Medical Association. The Council of the Ohio State Medical Association further commended Dr. Cromartie for his outstanding service to medicine and to the public, at its September 19-20 meeting.

The Intensive Care Unit of Miami Valley Hospital was also presented with the Superintendent's Citation of Merit on December 30, 1969. This citation states "For their unwavering devotion to duty in the constant care of Highway Patrolman Gerald D. Riley during his five-month stay at Miami Valley Hospital. All Ohio State Highway Patrol officers join with Patrolman Riley in expressing their heartfelt thanks and deep appreciation to each member of this highly trained and gifted medical team."



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during August. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

FRANKLIN
- Greg K. Castetter, Columbus
- Joel M. Ginsberg, Columbus
- Ronald Litvak, Columbus
- W. Jerry McCloud, Columbus
- Bruce P. Meyer, Columbus
- John P. Minton, Columbus
- Lester R. Mohler, Columbus
- Patrick J. Moore, Columbus
- Albert M. Russell, Columbus

GREENE
- Juan R. Antuna, Xenia

LUCAS
- James R. Patrick, Toledo
- Francisco E. Pflaum, Toledo
- Iqbal Singh, Toledo

MAHONING
- Charles A. Crans, Youngstown
- Michael F. Sheridan, Youngstown
- Earnest Perry, Youngstown

MONTGOMERY
- Michael A. Jaffe, Dayton
- Raynald A. Lane, Dayton

Following are names of new members of the Ohio State Medical Association certified to the headquarters office during September. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA
- Victor E. Albainy, Cleveland
- Moises L. Buzon, Cleveland
- Robert B. Eppes, Cleveland
- Charles R. Hoyt, Berea
- John Robert Judge, Cleveland
- Finley F. Neuman, Cleveland
- H. Veladi, Cleveland

FRANKLIN
- Philip E. Jarvis, Columbus
- Robert H. Montgomery, Worthington
- Joseph A. Prescott, Columbus
- William Reynolds, Columbus
- Helmut S. Schmidt, Columbus

HAMILTON
- James J. Arbaugh, Jr., Cincinnati
- Bahram Kadivar, Cincinnati
- Alan D. Manzler, Cincinnati
- Elaine Y. Rosin, Cincinnati
- Rosemary E. Schmidt, Cincinnati
- Corwin M. Smith, Cincinnati
- Paul A. Spaccarelli, Cincinnati
- Ralph E. Yodaiken, Cincinnati
- Marvyn H. Youkilis, Cincinnati

PORTAGE
- Donald Hammel, Ravenna

ROSS
- Max R. Hickman, Chillicothe

SENECA
- Eulogio V. Ganaden, Tiffin

SUMMIT
- Jose C. Albovias, Cuyahoga Falls
- Thomas J. Jackson, Akron

CLARK
- Jeffery B. Blackburn, Yellow Springs
- Thomas M. Board, Jr., Springfield
- George A. Cochran, Jr., Springfield

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Mount Vernon, Ohio, U.S.A.



Menrium® treats the menopausal symptoms that bother him most.



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His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through her menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

KEEPING UP:

Continuing Education Opportunities for Physicians in Ohio

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

November

Tri-State Meeting of the American College of Physicians (Ohio, Western Pennsylvania, and West Virginia) — at the Cleveland Clinic Educational Institute, 2020 East 93rd Street, Cleveland 44106; November 20-21; for members and nonmembers of the college; contact the ACP at 4200 Pine Street, Philadelphia, Pa. 19104.

Neurology Conference — Sponsored by Ohio State University College of Medicine, at OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, November 20.

Chemotherapy in the Patient with Incurable Cancer (Pharmacology Series) — Youngstown Hospital Association; November 23; Dr. W. D. Loeser and Dr. M. Kuangparichat.

Inappropriate Breathlessness — Dyspnea — Trumbull Memorial Hospital, Warren, luncheon program, November 24; George W. Wright, M.D., head, Department of Medical Research, St. Luke's Hospital, Cleveland, and associate clinical professor of medicine, Case Western Reserve University.

December

Obstetrics and Gynecology — Sponsored by the University of Cincinnati College of Medicine and CONMED, at Christ Hospital, Elland Avenue, Cincinnati, December 3.

Ocular Surgery, Glaucoma and External Disease — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland; December 9-10.

Current Concepts in Ophthalmology — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, 44106; December 9-10; Contact Walter J. Zeiter, M.D., Director of Education at the clinic.

Spinal Cord Injuries Conference — Ohio State University College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, December 10.

Electrolyte and Fluid Balance — At Jewish Hospital, Cincinnati; sponsored by the University of Cincinnati College of Medicine and CONMED; December 10.

New Antibiotics — Gentamycin, Carbentocillin and Others (Pharmacology Series) — Youngstown Hospital Association; December 14; Dr. G. A. Butcher and Dr. J. Conti.

January

Fifty Years of Surgical Progress—Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; January 13-14.

Recognition, Evaluation, and Control of Occupational Hazards — Training Institute, Environmental Control Administration, 1014 Broadway, Cincinnati 45202; January 18-22.

Orthopaedic Challenges — Reconstructive and Post-Traumatic — Cleveland Clinic Educational Foundation, January 20-21.

Selected Aspects of General Medicine — Sponsored by the University of Cincinnati College of Medicine and CONMED, Eden Avenue, January 20-21.

New Endoscopic and Camera Techniques (Gastroenterology Series) — Youngstown Hospital Association, January 25.

Tests of Pulmonary Gas Transfer—Clinical Problems of O_2 - CO_2 Exchange — Trumbull Memorial Hospital, Warren, luncheon program, January 26; Edward H. Chester, M.D., head, Pulmonary Section A, Veterans Administration Hospital, Cleveland, and assistant professor of medicine, Case Western Reserve University.

New Developments in Special Procedures, Complications and Legal Implications — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; January 27-28.

February

General Practice — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, February 3-4.

Educational Opportunities in Ohio—*Continued*

Hospital Infection Control — Sponsored by the University of Cincinnati College of Medicine and CONMED at the Shriners Burns Institute Auditorium and Cincinnati General Hospital, February 4.

Hepatitis: Subacute Hepatitis, Chronic Active Hepatitis (Gastroenterology Series) — Youngstown Hospital Association, February 8.

Disorders of the Red Cell — Cleveland Clinic Educational Foundation, February 10-11.

Facial Fractures — Repair and Plastic Surgery — Sponsored by the University of Cincinnati College of Medicine and CONMED at the Shriners Burns Institute Auditorium and Cincinnati General Hospital, February 15-19.

Granulomatous and Nongranulomatous Colitis (Gastroenterology Series) — Youngstown Hospital Association, February 22.

Physiologic Bases of Assisted Ventilation — Applied Respiratory Mechanisms — Trumbull Memorial Hospital, Warren; luncheon program, February 23; John J. Picken, M.D., instructor in medicine, Case Western Reserve University.

Electromyography — Ohio State University College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road, Columbus, February 23-25.

Review of the Connective Tissue Diseases by Systems. Manifestations and Management — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; February 24-25.

March

Ophthalmology Conference — Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus; March 1-2.

Selected Basic Science Applications to the Modern Clinical Laboratory — At Christ Hospital, Cincinnati; March 4; sponsored by CONMED and the University of Cincinnati College of Medicine.

Lederle Symposium — Cosponsored by the Ohio Academy of General Practice, at the Sheraton-Columbus Motor Hotel, downtown Columbus, March 7.

Drug-Induced Thrombocytopenia and Hemolytic Anemia (Hematologic Series) — Youngstown Hospital Association, March 8.

Pediatric Clinic Day — At Children's Hospital, 561 S. 17th Avenue, Columbus; sponsored by the Ohio State University College of Medicine; March 10.

Advances in Urology — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; March 10-11.

Lederle Symposium — Cosponsored by Ohio State University College of Medicine, at the Sheraton-Columbus Motor Hotel in downtown Columbus, March 14.

Internal Medicine — Sponsored by Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, March 17.

Shriners Burns Institute Symposium on Thermal Injuries — at the Shriners Burns Institute, March 18-19; sponsored by CONMED and the University of Cincinnati College of Medicine.

The Examination of Bone Marrow (Hematologic Series) — Youngstown Hospital Association, March 22.

Clinical and Radiological Aspects of Chronic Obstructive Pulmonary Disease — Trumbull Memorial Hospital, Warren; luncheon program, March 23; Gerald L. Baum, M.D., head Pulmonary Section B, Veterans Administration Hospital, Cleveland, and associate professor of medicine, Case Western Reserve University.

International Conference on Non-Ionizing Radiation Safety — at the Sheraton-Gibson Hotel, Cincinnati, March 29-31; under combined auspices of the U.S. Public Health Service, Bureau of Radiological Health, and the Laser Laboratory of the Medical Center, University of Cincinnati; contact: Laser Laboratory, Children's Hospital Research Foundation, Elland Avenue and Bethesda Avenue, Cincinnati 45229; (Followed by course on **The Applications of the Laser in Biology, Medicine and Dentistry**, April 1-3 — See under April.)

Infectious Diseases — Sponsored by Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, March 31.

Updating Neurology — Cleveland Clinic Educational Institute, 2020 East 93rd Street, Cleveland 44106; March 31 - April 1; for specialists and nonspecialists.

(Continued on Next Page)

April

The Applications of the Laser in Biology, Medicine and Dentistry, at the University of Cincinnati Medical Center, April 1-3; contact Leon Goldman, M.D., Laser Laboratory, Children's Hospital Research Foundation, Cincinnati 45229; or phone 513-281-6156 — Ext. 405. (This course follows the **International Conference on Non-Ionizing Radiation Safety** — See under March.)

Fourth Annual Cancer Symposium — Sponsored by Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus: April 7.

The Hemostatic Process (Hematologic Series) — Youngstown Hospital Association, April 11.

Symposium on Anesthesiology — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; April 14-15.

Anesthesia Conference — Ohio State University College of Medicine, Columbus; at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus; April 16.

Respiratory Failure — Trumbull Memorial Hospital, Warren; April 27.

Tri-State ACP Meeting Scheduled in Cleveland

The Tri-State Meeting of the American College of Physicians, including physicians of Ohio, Western Pennsylvania, and West Virginia, will be held at the Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106, on Friday and Saturday, November 20 and 21. The announcement was made by Charles H. Rammelkamp, Jr., M.D., of Cleveland, Ohio governor for ACP.

An outstanding scientific program has been arranged by the Program Committee under the chairmanship of Howard S. Van Ordstrand, M.D. Nonmembers as well as members of ACP are invited. Contact Dr. Van Ordstrand at the Cleveland Clinic, or the ACP at 4200 Pine Street, Philadelphia, Pa. 19104.

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The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



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Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

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Obituaries

Frederick Max Cluff, M.D., Middleport; University of Kansas School of Medicine, 1932; aged 66; died September 16; former member of the Ohio State Medical Association; practicing physician in Middleport; returned to Middleport in 1965 after ten years of residence in Kansas; survived by his widow, two daughters, two sons, and a sister.

Frank Baker Ficklin, M.D., Toledo; St. Louis University School of Medicine, 1913; aged 83; died September 22; former member of the Ohio State Medical Association; practicing physician in Toledo for most of his professional career; veteran of World War I; member of the Methodist Church.

Michael Christopher Geraci, M.D., Cleveland; Washington University School of Medicine, 1927; aged 70; died September 10; member of the Ohio State Medical Association and the American Medical Association; general practitioner in Cleveland for 41 years; former physician for the Cleveland Boxing Commission; survived by his widow, two sons, and two sisters.

Robert Franklin Hecker, M.D., Orrville; Western Reserve University School of Medicine, 1927; aged 70; died September 20; member of the Ohio State Medical Association and the American Medical Association; general practitioner in Orrville since 1931; veteran of World War I; member of the American Legion, and the Methodist Church; survived by his widow, and a sister.

Henri Arthur Kerns, M.D., Kenton; Ohio State University College of Medicine, 1935; aged 66; died September 13; member of the Ohio State Medical Association and the American Medical Association; practitioner in the Kenton area for virtually all of his professional career; veteran of World War II; survived by his widow, a daughter, a son, a brother, and four sisters.

Harland Paige McGregor, M.D., North Lima; Ohio State University College of Medicine, 1935; aged 68; died September 3; member of the Ohio State Medical Association, the American Medical Association, American Academy of General Practice, and the American Geriatrics Society; practitioner in the North Lima area of Mahoning County since 1937; civic leader and active in the Little League baseball organization. Business, Industrial and Professional Organization, the School Board, athletic organizations, the United Church of Christ; survived by his widow, two sons, and a sister.

David Steel, M.D., East Falmouth, Mass.; Johns Hopkins University School of Medicine, 1920; aged 77; died September 9; former member of the Ohio State Medical Association; Fellow of the American College of Radiology; diplomate of the American Board of Radiology; practitioner in Cleveland until his retirement in 1961; associated with radiology departments of University, St. John and Deaconess Hospitals; member of several Masonic bodies; survived by his widow, a son, a daughter, and two brothers.

Kathryn Helen Svec, M.D., Cleveland; Western Reserve University School of Medicine, 1954; aged 42; died September 13; member of the Ohio State Medical Association and the American Rheumatism Association; diplomate of the American Board of Internal Medicine; private practitioner, specializing in rheumatology, and assistant professor of medicine at Case Western Reserve University; survived by her parents, a sister, and her grandmother.

Command Assignment at Wright-Patterson AFB

Colonel Clinton L. Holt, former director of bioastronautics at the Air Force Eastern Test Range, has assumed command of the Aerospace Medical Research Laboratory at Wright-Patterson Air Force Base, Ohio.

He graduated from Antioch College, at Yellow Springs, and received his M.D. degree from Western Reserve University School of Medicine in 1953. He also holds a master's degree in public health from Harvard University.

Prior to his assignment with the U. S. space program at Patrick AFB, Florida, Colonel Holt was chief of the Operational Bioastronautics Division and later assistant director of bioastronautics for the former Manned Orbiting Laboratory program in Los Angeles.

He has served overseas as commander of the U. S. Air Force Hospital, RAF Alconbury in the United Kingdom and as flight surgeon at Incerlik Air Base in Turkey.

The laboratory at Wright-Patterson is part of the Air Force Systems Command's Aerospace Medical Division with headquarters at Brooks AFB in Texas.

County-Community Activities

There Must Be a Better Way

Under the above title, Thomas E. Shaffer, M.D., as guest editor for the *Bulletin* of the Academy of Medicine of Columbus and Franklin County, discusses the physician's role in the growing request for pre-camp physical examinations and the responsibilities that go with such undertakings. He begins as follows:

"Now is the time, before another camping season comes around, for the Academy of Medicine to take the leadership, in cooperation with youth-serving agencies, in developing reasonable policies about pre-camp physical examinations. As physicians we have a responsibility for encouraging maintenance of good health and preventive medicine, but we also have a duty to stress rational medical care and conservation of health service manpower.

"The point in question is the requirement by various agencies for routine health examinations of children just before they go away to camp or participate in other recreation programs. The problem has always been with us but has increased because of the larger number of inner city children who go to community camps each summer. Requests for last-minute examinations of a great many children are frustrating, because they have not been scheduled, the quality of the examination has to be less than satisfactory, and yet the children stand to lose out on a good experience if they are not seen by a physician. . . ."

Alleviating Doctor Shortage, Year's Theme in Toledo Area

The president of the Academy of Medicine of Toledo and Lucas County, Roland L. Kennedy, M.D., writes in part in the September issue of the *Bulletin:*

"This spring for the first time the Academy was unable to fulfill one of its most important functions to the community, that of finding physicians in response to requests coming into the office. A large block in the physician section of the yellow pages of the phone directory in effect offers the assistance by the Academy to patients seeking doctors.

"Twenty-one primary physicians (generalists, internists, and pediatricians) were lost by the community during the last year. About half were in fully committed busy practices. Death claimed several. Some are seeking refuge in other types of practices such as the specialties and emergency rooms. Regardless of the cause, a deficit has been created which has profound implications. The patients of these physicians are asking to be taken into the practices of other doctors. In addition, new residents in the community are asking the Academy for physicians who will take new patients. Looking to the new physicians entering the community, there have been no replacements in the primary category. . . ."

Further editorial comment announces that the doctor shortage will be one of the leading themes in issues of the *Bulletin,* along with features to stimulate the interest of the membership.

Study Academy Reorganization Plans

The Academy of Medicine of Cincinnati has under study a plan to streamline the structure of the organization. In a recent issue of the *Cincinnati Journal of Medicine,* Robert S. Heidt, M.D., 1969-1970 Academy president, wrote in part as follows:

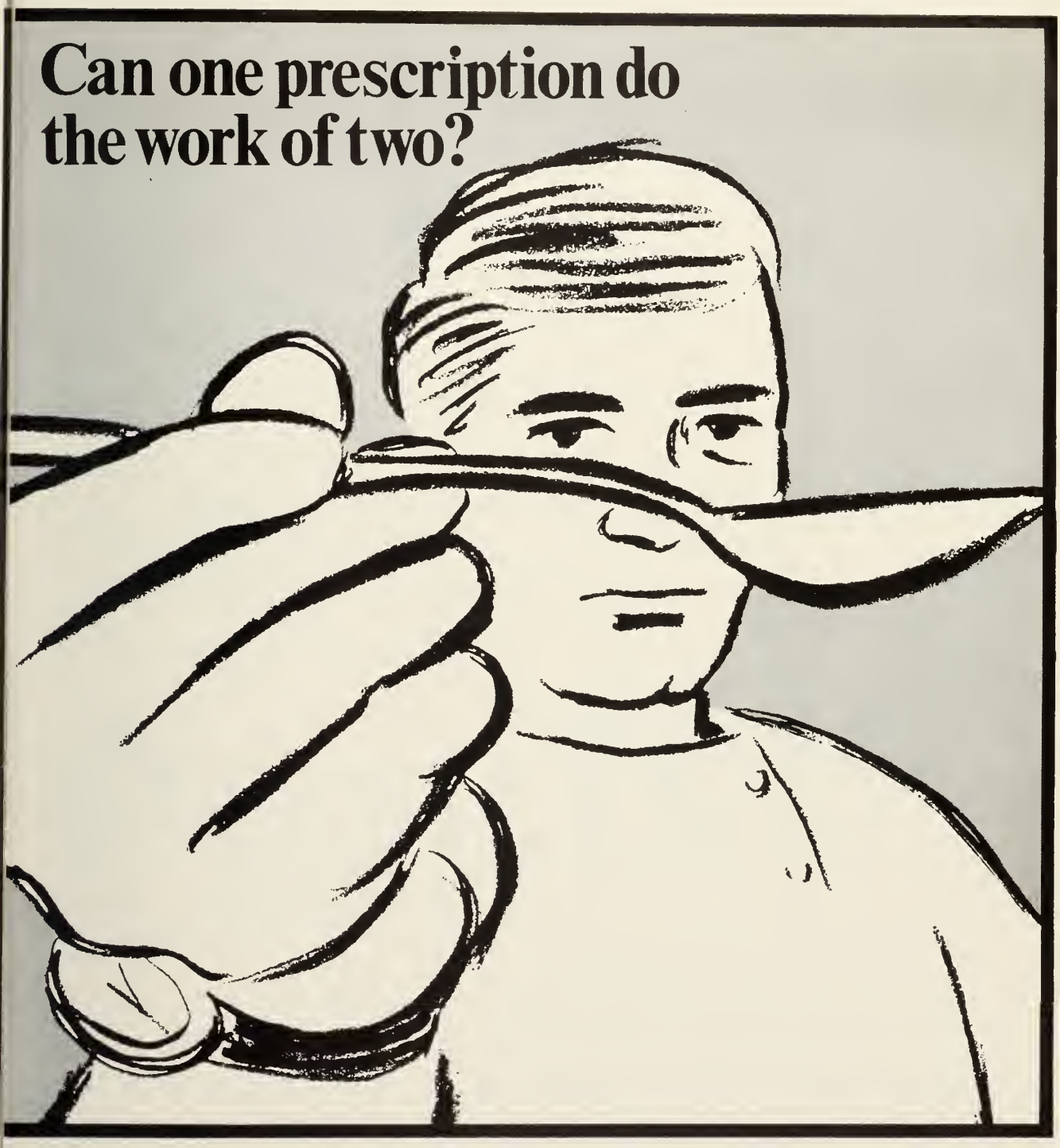
"The Executive Committee of the Academy has met on reorganization of the structure of the Academy. We have written to several other county health societies in reviewing the possible change of the Academy to a commission structure rather than that of committees. This would involve five or six commissions that would handle all of the committee affairs of the Academy. Probably beneath these commissions would be various subcommittees and these would report to the commission. It is thought this way that the affairs of the Academy could be much more easily handled with a much better coordination of activity. The way it stands now we have many committees whose function is somewhat obscure and whose operation is diminished for a lack of proper coordination with other functioning groups of the Academy. This is going to take some time to verify because it is a new concept and because we do not have a good pattern to follow. The other organizations are not structured quite the way we are. It will be interesting to see the end result. . . ."

Mahoning County Earns Big "A" on Report Card

The following note appeared in a recent issue of the *Bulletin of the Mahoning County Medical Society:*

"The Mahoning County Medical Society, headquartered in Youngstown, Ohio, earns some

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of its best marks in public relations in school. It has a complete program to serve both the schools and students. One of its most widely heralded ventures is awarding the AMA's popular book, *Today's Health Guide,* to the winners of the *Youngstown Vindicator's* annual Spelling Bee, with concomitant publicity and credit.

"The Society has also placed the *Guide* in each high school's library, and pays the subscriptions for *Today's Health* magazine for all county high and junior high schools. It hosts an annual scholarship dinner and presents a pin and certificate to the top boy and girl scholar in each of the county's 22 high schools. At the annual Tri-County Science Fair, the Society honors the students with the best medical exhibits with a trophy and one $50 and two $25 checks, and the Society's Foundation makes loans to medical students from the area."

More Operating Money Needed by Cleveland Academy

Earlier this year the Academy of Medicine of Greater Cleveland failed to approve a dues increase by 22 votes short of the two-thirds majority required. Of ballots mailed to the membership, 1425 were returned—928 for, and 497 against.

In the October issue of the *Cleveland Physician,* Academy President Vincent T. LaMaida, M.D., reviewed the situation and asked members to reconsider the budget situation. He wrote, in part:

"The Board of Directors and I have come to you before asking that you approve of a dues increase. We have come to believe that we have a personal interest in this—and we do, the same interest that you have—keeping our Academy at top level. We are the sixth largest county society in the country, larger even than all but fourteen state societies.

"The inflationary trend has affected the Academy operations as it has all other organizations. Our financial deficit this year could approach $10,000, and by the end of 1971 it will be $20,000. Knowing this, your Executive Committee, with the consultation and advice of Mr. Lang and other staff members, met with the intent of tightening our budget and reviewing priorities of expenditures. The staff suggested several areas where money could be saved, but in each instance some member of the Executive Committee would point out the importance of the function or activity which was to be curtailed. . . ."

Lorain County Doctors Honor Scholarship Winners

At the first Fall Meeting of Lorain County Medical Society on September 8, members and wives were hosts to the Board of Supervisors of Lorain County Medical Foundation and their wives, and 11 students who received scholarships from the Foundation.

Dr. William R. Schultz, of Wooster, Eleventh District Councilor, and Mrs. Schultz were guests of honor on this occasion.

The Medical Foundation, initially established several years ago by the Medical Society following a Polio Immunization program, annually awards scholarships to students studying towards careers in health-related fields. This year, the recipients included two in Medicine, one in Veterinary Medicine, one in Pharmacy, six in Nursing, and one in Practical Nursing.

Jack P. Mercer, M.D. of Lorain, headed the Screening Committee which had interviewed eligible candidates earlier in the year, and the scholarship checks were presented to the students

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at the September 8 Meeting, by Otto B. Schoepfle, Vice-Chairman of the Foundation's Board of Supervisors.

At this time, a donation in the amount of $1,000 was presented to the Foundation's Scholarship Fund by the Medical Society. The gift was made possible with the balance of money from the recent Rubella Immunization Program, which had been cosponsored in the spring of 1970, by the Medical Society, the Lorain County Health Department, and the City Health Departments of Lorain and Elyria.

In making the presentation on behalf of Richard A. Moore, M.D., Chairman of the Rubella Planning Committee, Dr. McFarland commended the committee members for their efforts in ensuring a successful program—which immunized between 85 and 90 percent of the children eligible in the various areas throughout the County.

He paid special tribute to those who volunteered time and money to make this possible—physicians, nurses, pharmacists, school administrators, the Woman's Auxiliary to the Medical Society, technicians, PTA groups and many others.

Actively participating as members of Dr. Moore's Committee were Drs. M. A. Amiri; J. A. Cicerrella; D. D. Mason; A. M. Mattey; Ted A. Gray; and Marion G. Fisher, County Health Commissioner, who was instrumental in obtaining sufficient vaccine from the State Department of Health.

Home Health Services Discussed in Belmont County

The subject "Home Health Services" was discussed on September 17 at the Belmont County Medical Society meeting. Guest speaker was Dr. Paul S. Metzger, Columbus, health and medical director for the Nationwide Insurance Company. The program preceded a dinner meeting with the Auxiliary at the Belmont Hills Country Club.

The Arthritis Foundation has announced its 1970 competition for outstanding reporting in newspapers, magazines, radio, and TV, a top prize of $500 being offered in each category. A committee of authorities in all four media will judge entries for accuracy, originality and potential for stimulating greater public knowledge, understanding and concern about the nationwide problem of arthritis and other rheumatic diseases. Persons interested may write The Arthritis Foundation, 1212 Avenue of the Americas, New York, N. Y. 10036.

MDs in the News

Dr. Norman M. Glazer, chief of the medical staff and director of radiology at Akron Children's Hospital, was installed as president of the American Society for Pediatric Radiology during the organization's convention in Miami Beach, Florida.

Dr. Woodruff C. Adams, Toledo, has been named to a nine-year term on the University of Toledo's Board of Trustees. Dr. Adams is a member of the Ohio State Medical Association, the American Medical Association, the National Medical Association, and numerous other professional and civic organizations.

Dr. Irvine H. Page, Cleveland, and Sir George W. Pickering, of Oxford University, shared honors in this year's awarding of the Vernon Stouffer Foundation award, including $50,000 in cash. The award was made at the annual meeting of the Council for High Blood Pressure Research of the American Heart Association. Dr. Page was cited for "Unparalleled statesmanship in medical science" and original discoveries in causes and treatment of hypertension.

Colleagues of the late John A. Mackie, M.D., have presented Mercy Hospital, Hamilton, with a plaque in his memory. The plaque has been placed in the main lobby of the hospital. Dr. Mackie died in July of 1969 after practicing in the community for some 38 years.

What To Write For

Noise—The Third Pollution—A Public Affairs Pamphlet, published in the public interest by this non-profit organization; explains noise, what it does physically and psychologically, and what action can be taken on the community level "to quiet our society." Available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016. Leaflet contains listing of other available pamphlets with price list.

How to Help the Alcoholic, a new Public Affairs Pamphlet by Pauline Cohen is written for the public and offers guidance to families in which alcoholism is a problem. Physicians may wish to make it available in their waiting rooms, or use it as a supplement to counseling of selected patients. Available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016.

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati, Ohio 45243

CROWN INN IN COLUMBUS was the scene of the annual fall conference of the auxiliary on September 29. As she welcomed "F"rybody to our new Fall Fact Forum, Mrs. R. L. Wiessinger, president-elect quipped, "Our fervent foremen are forever fighting to present all the features and facts they can find for this fiscal year!"

State officers and committee chairmen conducted the various sessions to inform county auxiliaries of plans and projects for the year. Here are some of the salient points given.

Health Careers

Mrs. H. I. Humphrey, chairman, stated that ten percent of all high school graduates are needed in the health field. Auxiliary members should continue their excellent work with Health Careers Clubs and their sponsorship of Health Careers Days. Poster contests in schools and exhibits at fairs offer additional means of bringing the opportunities in the health field to the attention of the public.

Mrs. Humphrey introduced Mrs. Monica V. Brown, director of Health Manpower Programs for the Ohio State Regional Medical Programs. A new organization, Health Careers of Ohio, is being established to coordinate health career planning and recruitment in the four Regional Medical Programs of the state. Mrs. Brown indicated that a major first step is to provide up-to-date career information. A descriptive folder "Over 200 Health Careers" is available for distribution through schools, health professionals' offices, and libraries. It contains a postage-paid reply card for students to use in requesting information about specific careers. Physicians, especially, are urged to display these brochures in their offices.

Mental Health

Mrs. L. A. Loria, chairman, outlined the major emphasis for the year in the promotion of good sound mental health. "Start with yourself, then your family, and finally, your community." Read such books as *The Art of Loving* by Eric Fromm, and *The Mature Mind* by Harry Bonaro Overstreet; have two or more friends read them; discuss them at a neighborhood coffee. Subscribe to a variety of magazines for all age children; point out pertinent articles for your children and your husband; discuss them. Tell community groups about the mental health package programs and materials available through the auxiliary. Volunteer to work in Mental Health centers and assist with fund raising events.

Parliamentary Procedure

Mrs. R. Cooks, chairman, gave a brief history of the development of parliamentary procedures and the publishing of the first manual in 1875 by Henry M. Robert. Assisted by Mrs. Reuben Gould and Mrs. Thomas Manning of Cuyahoga County, she presented a skit demonstrating how to conduct a meeting. The clever dramatization

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Carl F. Goll
1001 Granard Parkway
Steubenville, 43952

President-Elect
Mrs. Russell L. Wiessinger
2280 W. Wayne Street
Lima, 45805

Past President
Mrs. Samuel L. Meltzer
2442 Dorman Drive
Portsmouth, 45662

First Vice-President
Mrs. Rudolf O. Cooks
15830 Van Aken Blvd., Apt. 401
Cleveland, 44120

Second Vice-President
Mrs. Daniel Wolff
3963 W. Bancroft Street
Toledo, 43606

Third Vice-President
Mrs. H. I. Humphrey
389 S. Drexel Avenue
Columbus, 43209

Recording Secretary
Mrs. Emil L. Barrows
7181 W. Aracoma Drive
Cincinnati, 45237

Corresponding Secretary
Mrs. F. A. Sunseri
301 Woodridge Drive
Steubenville, 43952

Treasurer
Mrs. Paul Hahn
122 Moore Avenue, N.W.
New Philadelphia, 44663

was amusing as well as informative, with Mrs. Cooks as the ghost of Mr. Robert visiting a new club president. Correct terminology was stressed: you **approve** minutes, **accept** reports and **adopt** resolutions. The proper content of minutes was outlined, emphasizing that the secretary records action. How to handle motions, the order of business, and committee reports were also covered. Copies of the skit are available from Mrs. Cooks.

Safety and Self Defense

Mrs. Victor H. Hinricks, Safety chairman, stated that in 1969 there were five million serious crimes committed in the U.S. No one is immune; individuals are urged to take steps to avoid being a victim. Suggestions for ways to thwart a criminal are based on two major premises: (1) no criminal wants to be caught and (2) criminals abhor work. So don't make things easy for him!

Mrs. Hinricks outlined many points for home security. She stressed the value of good locks, adequate lighting, and barking dogs. Look at your home through a burglar's eyes to spot weaknesses in your precautions.

Self defense for women is another area to be considered in the safety program. Women are advised to have an alarm (scream!), have a weapon (use your purse, your heels, your fingernails), and a defensive skill, if possible. There are many excellent pamphlets and package programs available from your chairman.

AMA-ERF

Contributions to the American Medical Association Education and Research Foundation help support medical education. Since 1951 auxiliaries nationwide have raised over $4,000,000 to help provide more physicians to care for our expanding population. Mrs. Karl Ulicny, Ohio's energetic chairman for a second year, displayed the many items available for sale to raise funds for AMA-ERF. She discussed the different types of Christmas cards sold and the "In Memorium" and "In Honor of" cards used for donations.

International Health

Mrs. Howard Smith, chairman, suggested the use of a book review or a film to inject enthusiasm among members for projects in International Health (and goodwill). She feels that every auxiliary should take out an organization membership to Project Hope which is celebrating its tenth anniversary this year. Other projects include: collection of sample drugs, *MD's wife*, international hospitality, Care, Medico, MAP, and the international book program.

Mrs. Max Schnitker discussed Project Hope in greater detail and outlined some of the programs Toledo has employed to raise $20,000 in the past four years for HOPE.

Communications

Mrs. H. W. Allison, NEWS editor, explained that the *Auxiliary News* is published four times a year with deadlines of August 1, November 10, March 1 and June 10. Mrs. Robert Krone, publicity chairman, stated that she needs news about the first of each month for the *OSM JOURNAL* column. Both discussed points in securing good pictures, and writing news releases.

Mrs. S. L. Meltzer stressed the importance of communications. Auxiliaries should communicate with their own county medical societies—"Try to get them to know you and help you." Auxilians should communicate with each other through newsletters. It is important also to communicate with other organizations in your town. Offer to speak to groups, or to help with programs. Use the auxiliary "Health Reporter" radio broadcasts to reach individuals in your community with health facts.

Health Education and Community Service

Mrs. Henry Holden, chairman, stated that the Blood Donor program should be given priority this year. Other programs which should be emphasized are drug abuse, the increase of VD, birth defects, antismoking campaigns and sex education. Materials are available in all of these areas.

Mrs. H. W. Haverland, chairman, Children and Youth, discussed some of the same problem areas and showed a film on drug abuse. There are three films available from Ohio Medical Indemnity on the drug culture.

Legislation

Mrs. Paul Jones urged auxilians to become politically active as individuals and to give financial support to candidates of their choice. This is a year of decision with national health insurance being proposed under several different plans. Be informed, be active.

Membership

Mrs. D. S. Wolfe, chairman, raised the question: "How do we make membership in the medical auxiliary so important to each doctor's wife that she feels this is her own special organization?" This is the Big M year—manpower, motivation

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Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include anes such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libida, dysuria, and polyuria.

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and mobilization for action. We need woman-power to carry out the programs of the auxiliary.

Membership is the responsibility of every member, not just a chairman or a committee. However, county presidents and membership chairmen must seek ways to overcome complacency and indifference, remembering that auxiliary membership implies responsibility to meet current challenges, as well as providing opportunities for related social activities.

Membership must be meaningful in order to enroll and retain new members, re-enlist old members and reclaim dropouts. Evaluate your activities frequently to make sure you have considered the three essential ingredients in "holding power"—warmth and gracious fellowship, interesting and informative programs and challenging and worthwhile projects.

Increases in membership are the result of dedicated and knowledgeable county auxiliary members. It is at the county level that the majority of new members are recruited; it is at the county level that the auxiliary must relate to the problems of the times and to the needs and concerns of its members, the medical society and the community, if we are to continue to grow.

Program

Mrs. R. L. Wiessinger, president-elect, discussed programs for auxiliary meetings. She suggested that counties give first priorities to those set up by national chairmen. "To insure success, involve your membership; have everyone working!" Don't overlook the fact that husbands of members can give good programs. Invite other groups such as dental and bar auxiliary members.

Mrs. Wiessinger closed her discussion with a review of members' reactions to the Fall Fact Forum. This had really been a day of action, of learning and of fellowship. Much credit was due to the untiring work of the two chairmen of the day from Montgomery County, Mrs. Howard Kircher and Mrs. Norman Rose.

Note to County Publicity Chairmen: News notes from counties will be included next month so keep sending your clippings, newsletters and announcements.

John W. Castellucci recently announced his retirement as president of the National Association of Blue Shield Plans, effective on November 1, 1971. Ned Parish, executive vice-president of the Chicago based organization has been designated to succeed him.

Break Ground for Toledo Medical School

In a brief ceremony on September 11, Governor James A. Rhodes and officers of the Medical College of Ohio at Toledo broke ground for the college's first major buiding — the $9.5-million Health Sciences Teaching and Laboratory building.

The event marked the start of construction on the 346-acre new campus on Arlington Avenue in Toledo.

Dr. Glidden L. Brooks, college president; Paul Block, Jr., chairman of the Board of Trustees; Dean Robert G. Page; and Lurley Archambeau, president of the student body, shared in the task of turning the first few spadesful of earth to mark the start of the new building.

Scheduled for completion in 1972, the structure will contain the major teaching and laboratory facilities for the departments of anatomy, biochemistry, pharmacology and physiology.

It will include a basement and four floors built around an 88 x 55 foot interior court. Measuring 234 x 135 feet overall, the building will have about 155,000 square feet of interior space.

The basement and first floor will house the offices and laboratories of the department of anatomy, along with special rooms for tissue culture, electron microscopy and autopsy.

Two lecture halls, seating 120 persons each will be on the first floor.

The second floor will accommodate the department of pharmacology, radioisotope room, electrically shielded lab, animal facilities, seminar and conference rooms, toxicology lab, cold room and shop.

Comparable facilities for the physiology department will be on the third floor, and for the biochemistry department on the fourth floor. Each of the upper three floors will have four large multi-purpose laboratories.

Dr. Brooks said the new building "is one of the major steps in the development of the Medical College. When it is complete, we shall be able to increase the size of each entering class toward our projected goal of 100 students per year.

"This, in turn, means that we can provide still more doctors to serve the health needs of the community. Therefore, we are extremely pleased with the excellent support of the General Assembly and the State Administration which is reflected in the start of this first building on the new medical campus."

Highlights in Ohio Welfare

Welfare Department Is Processing Claims Much Faster in Spite of Increased Volume

PAST PERFORMANCE is a good yardstick with which to measure improvement. In the area of health care vendor payments—that is, payments made to providers of health care services, including physicians—a comparison of present performance with that of two years ago reveals that the Division of Administrative Services is processing a greater volume of payments, with fewer rejected bills, with fewer duplications, and in a shorter period of time.

By way of comparison, two years ago the Division was processing a stack of bills approximately 200 feet high — every 30 days; now the stack has reached nearly 300 feet! The number of vendors to whom the bills were paid has increased from 16,000 to more than 18,800, including 9,877 physicians. (The latter totals are based on the number of vendors and physicians for whom bills were paid during the fiscal year ending June 30, 1970). The total number of invoices were actually 5,662,382 during the 12-month period!

Another indicator of the increase in volume is the number of dollars spent. In the 12-month period ending June 30, 1970, vendor payments totaled slightly more than $121 million, or an average of nearly $10.1 million per month. Monthly expenditures in early 1968 stood at far less than one-half that amount — approximately $4 million.

Providers of services, including physicians, must also be credited with an increase in efficiency. Two years ago 25 percent of all bills submitted were rejected because of improper or insufficient information. Currently, only 10 percent are being rejected, cutting reprocessing time by more than half. Every indication is that the new payment procedure which was begun on October 1 will not decrease the efficiency level achieved by the providers. It should be emphasized—again—that bill processing and payment to physicians is expedited by the use of AMA's publication, *Current Procedural Terminology*, Second Edition.

Yet another measurement of improvement is the time lapse between receipt of a vendor bill and payment of that same bill. In April 1968, normal processing time was 60 days; the latest analysis of a random sample indicates that most bills—properly itemized and submitted—require only 22 working days (approximately 30 calendar days) before a check for payment is ready for mailing. In other words, the time lapse between receipt and payment has been cut almost in half.

Duplicate payments have also been reduced. Two years ago, computers in the Data Processing Unit were programmed to check a new billing against **all** bills paid during the four months immediately preceding payment of the new bill. Now, the new bill is checked against all bills paid during an **eight**-month period immediately preceding payment of the new bill. The newer procedures entail checking the bill being considered for payment against no less than 3,300,000 items—to insure that the "new" bill hasn't already been received and processed for payment! Bills older than eight months are checked manually to prevent duplication.

Everyone who works in the Division of Administrative Services will tell you that there's still room for improvement. But the evidence is conclusive: Some improvement has already been achieved!

Another change in policy is of special interest to physicians. Effective October 1, 1970 the Ohio Department of Public Welfare began paying all amounts designated as Medicare Part B **Co-insurance** to physicians and physician groups on behalf of all eligible Aid for Aged clients. The change does not affect billing procedures. Details of the change are set forth in a letter scheduled for mailing to all Ohio physicians.

This article was prepared for *The Journal* by personnel of the Ohio Department of Public Welfare.



Exhibits Wanted

1971 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association is just the place to display it. We are now accepting applications for the 1971 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be May 11, 12 and 13.

Mail application to the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

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CENTRALLY AIR CONDITIONED FULL SERVICE OFFICE: Prime University Heights, Cleveland Heights, South Euclid intersection. Excellent for Internist, General Practitioner, Ophthalamologist, or other specialist. Opposite May's on the Heights. Doctors Center Bldg. 14077 Cedar Road, Cleveland, Ohio 44118. Phone 216-321-5060.

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— More Classified Ads on Next Page —

CLASSIFIED ADVERTISEMENTS

(Continued from Previous Page)

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Editor's Note: The Journal presents the following classified advertisement to its readers as an announcement of the physician assistant and assumes no responsibility for the statements made.

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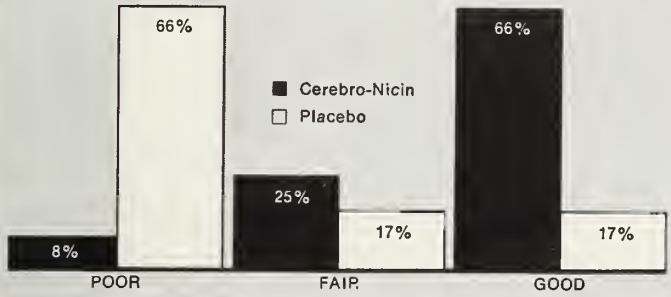
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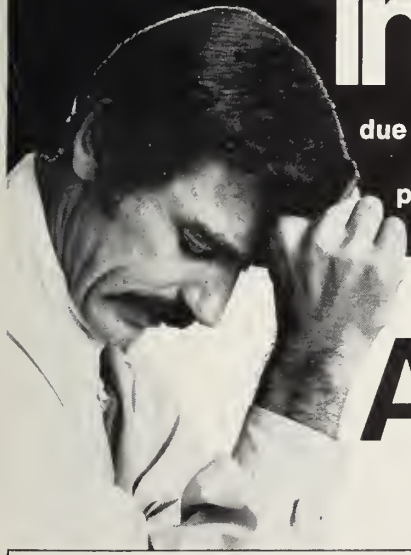
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Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Dose: 1 tablet 3 times daily.
Available:
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Available:
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Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.
Hypercalcemia may occur, particularly in immobilized patients; use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Dsol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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Excessive anxiety can often dominate the patient made vulnerable by illness, surgery, prolonged emotional stress. It can induce or aggravate symptoms, disrupt medical management, divert energy the patient needs for recovery.
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Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.
Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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DECEMBER 1970
Vol. 66 • No. 12

The Ohio State MEDICAL JOURNAL

21 DEC 1970

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION



In The Spirit of The Season

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Literature on indications and dosage available on request.

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Baltimore, Maryland 21201

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References:
(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.

The Ohio State MEDICAL JOURNAL

VOL. 66 DECEMBER, 1970 NO. 12

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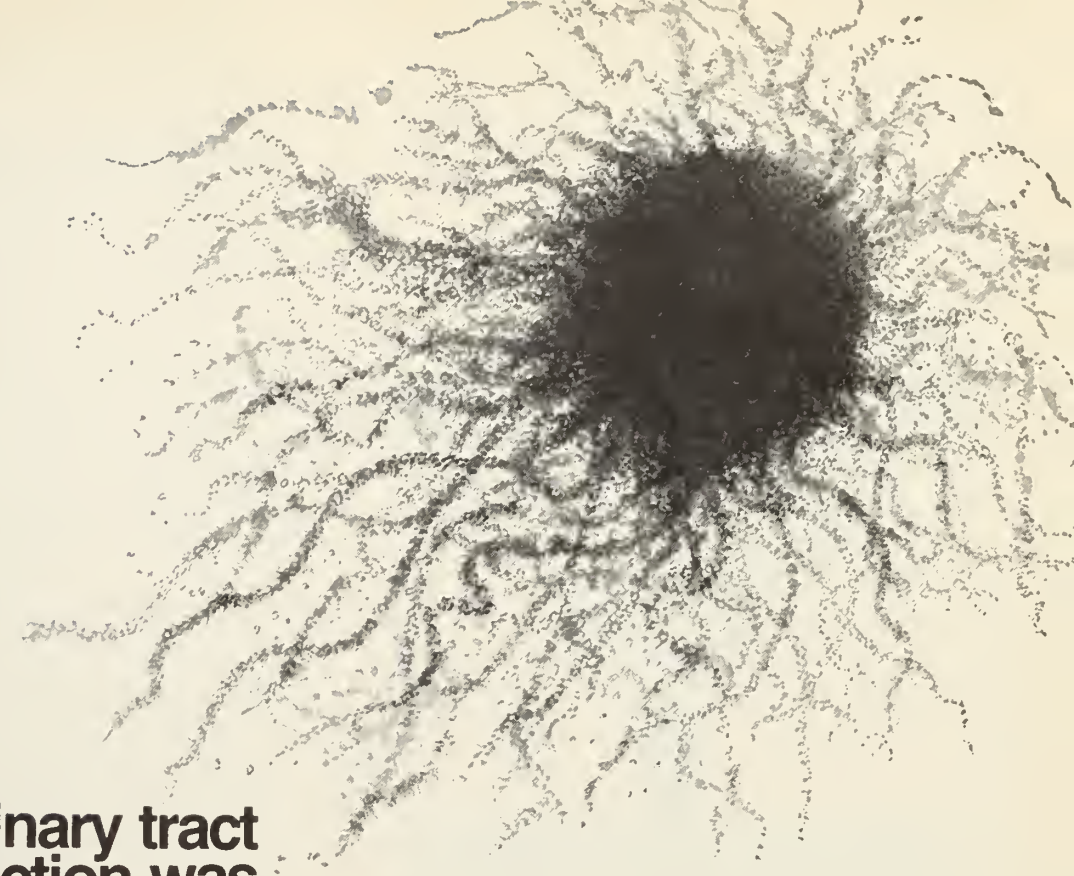
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A urinary tract infection was eliminated last week

ntestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

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Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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Multi-Media Teaching at Case Western Reserve Promoted by Grant

A Health Sciences Communication Center, linking the Case Western Reserve Schools of Medicine, Dentistry and Nursing—and eventually a wide variety of health agencies in a communications network in an effort to build a regional program of health education—will be established with a $1,524,000 grant from the W. K. Kellogg Foundation of Battle Creek, Michigan, CWRU Acting President Louis A. Toepfer announced. The sum will be paid out over a five year period, and must be supplemented by additional funds for equipment to be raised by the three schools.

Use of multi-media techniques at the Center will make it possible to accelerate and strengthen the supply of physicians, dentists and nurses for the health care needs of the community, will assist in providing continuing education for practicing professionals in the area, and offer opportunity for research in educational methods, it was stated.

Space for a sophisticated central studio and a communications system has been built into the $40,000,000 CWRU health sciences complex now nearing completion, and cooperative educational programs for the three schools have been in preparation for the past six years. Planning for the Center so far has been supported by the Gund Foundation of Cleveland.

Keynote of the instructional approach to be developed by the Center for the schools and other institutions will be emphasis on self-education and self-evaluation by the student of his own progress as preparation for a lifetime of professional growth. To cope with expanding enrollments in all three schools, more effective use of faculty time will be achieved by the use of television, audio and visual tapes and other teaching methods which are being designed. Instruction of students, staff and practicing professionals in affiliated hospitals in Cleveland, and possibly eventually in other hospitals in northeast Ohio, will be carried on from the Center by means of television and two-way radio.

Participating in the project will be the Division of Research in Medical Education, under the direction of T. Hale Ham, M.D., the Health Sciences Library, the CWRU Press, the School of Engineering and the Department of Instructional Support. The engineering facilities and consulting services of the Educational TV Association of Metropolitan Cleveland, a licensee of station WVIZ, will also be involved.

Six years ago John S. Millis, Ph.D., then president of Western Reserve University, set up a

Council for Cooperative Research and Development in Programs of Education in the Health Professions. Since that time, Dean Frederick C. Robbins of the medical school, Dean David B. Scott of the dental school and Dean Rozella M. Schlotfeldt of the nursing school and a representative committee have met regularly to plan a cooperative program and design a communications facility.

The three schools have built up considerable experience in multi-media teaching. Working with the Biomedical Communications Laboratory and AV-TV Facility, they have been experimenting with the use of technical aids to student learning. For several years in the individual schools, laboratory and clinical material has been taught by live closed-circuit TV and tapes.

Leadership in education has brought national recognition to the three CWRU health science schools. The curriculum introduced 18 years ago by the School of Medicine has served as a model for many medical schools in the United States and abroad. The School of Dentistry was one of the first dental schools in the country to give its fourth year students a large measure of independence in a comprehensive dental care experience. The School of Nursing has pioneered in establishing highly flexible programs providing varied approaches to undergraduate and graduate education.

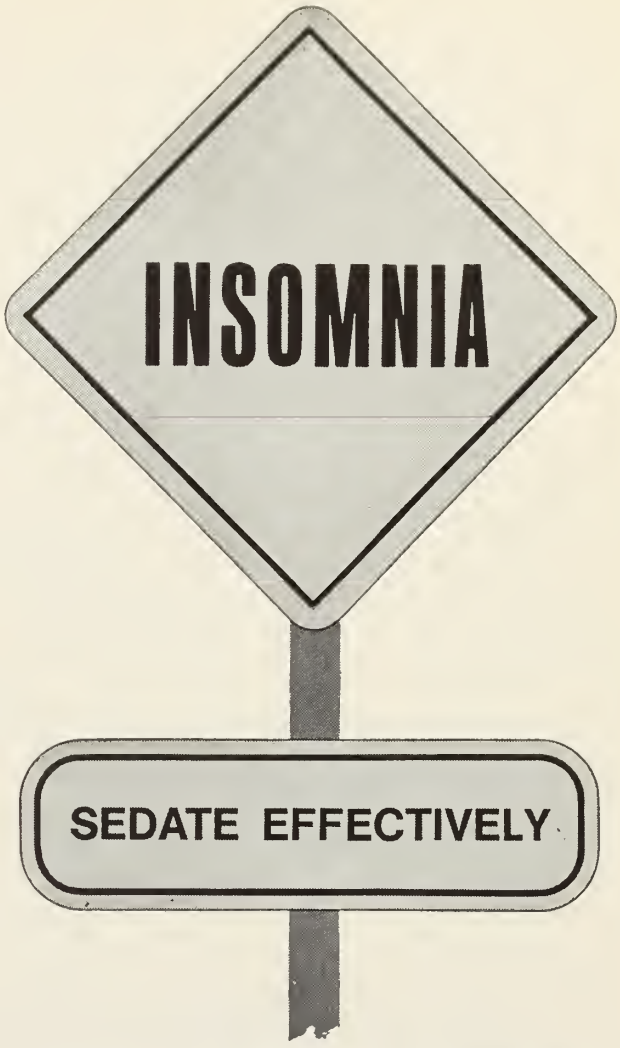
(Editor's Note: The foregoing news article was furnished by the Case Western Reserve University Office of Medical Information)

Organophosphate Poisoning Film Available

The Ohio Department of Health has announced that an educational film entitled "Organophosphate Pesticide Poisoning—Diagnosis and Treatment" is available for showing to medical and paramedical audiences.

The 16 mm color and sound film runs 19 minutes and may be identified as M1747-MP, 1969. The film describes the symptoms of organophosphate poisoning and includes a discussion of laboratory methods available for diagnosis and appropriate treatment for poisoned patients.

The film is available at no cost for showing to professional groups from: Lynwood Fiedler, Pesticides Program, Ohio Department of Health, 450 East Town Street, Columbus 43215.



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Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

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Distribution of Drug Abuse Pamphlets Totals 103,031

Records show that 103,031 copies of OSMA's popular drug abuse pamphlet, "What Everyone Should Know About Marihuana, LSD, Glue Sniffing, Amphetamines and Barbiturates," were distributed as a public service between October 20, 1969 and the same date in 1970.

According to the Committee on Mental Health, the demand for this publication "has yet to peak." Because of the strain on the budget, it was necessary earlier this year to limit lay persons and organizations to 100 copies. No limit "within reason" has been placed on orders from physicians and medical societies.

Typical of many comments from the public concerning the pamphlet is the following from the librarian of John F. Kennedy High School in Cleveland:

"We greatly appreciate your contribution to our educational endeavors. We like the information provided on these leaflets. It is concise and at the same time clear and definite. This is what so many library users look for."

The following breakdown indicates where the pamphlets were distributed during the first year.

Schools (guidance counselors, teachers, parents, student groups)	25,120
Law Enforcement People	14,200
Physicians (waiting rooms, talks, etc.)	13,945
Ohio Department of Health (and county health agencies)	11,591
County Medical Societies	9,420
4-H Clubs, Extension Groups, Ohio Rural Health Council	6,540
Clergy	6,200
Civic Organizations, Service Clubs	3,000
College Students and Educators	3,705
Girl Scouts, Boy Scouts, Campfire Girls	3,655
Libraries	195
Miscellaneous	5,460
Total	103,031

American Heart Association—Ohio Affiliate, Inc. is the new name for the organization formerly known as the Ohio State Heart Association. The headquarters office is at the same address, 10 East Town Street, Columbus, Ohio 43215.



Following are names of new members of the Ohio State Medical Association certified to the headquarters office during October. List shows name of physician, county, and city in which he is practicing, or in which he is taking postgraduate work.

CUYAHOGA
- Amelia B. Gruber, Cleveland
- Vidya C. Lalwani, Cleveland
- Edward G. Mansour, Cleveland
- Maureen D. McFadden, Cleveland
- Mary C. Milne, Cleveland
- Robert A. Quint, Cleveland
- Jesus A. Ramos, Cleveland
- Fouad Rashad, Cleveland
- Charles P. Van Tilburg, Chagrin Falls

LORAIN
- James C. Baker, Elyria
- Ronald A. Rollins, Oberlin
- William H. Sigalove, Elyria
- Tito S. Villegas, Elyria

SHELBY
- Charoen Savetamal, Sidney
- Ngampen Savetamal, Sidney

STARK
- Richard K. Cavanaugh, Canton
- Felipe J. Vilar, Louisville

Ohio Institute Researches Anticlotting Problem

Research is under way to improve the anticlotting and anti-infection properties of the cannulas used to link kidney patients and blood-cleansing hemodialysis machines. The research, which will involve coating interior and exterior walls of the cannulas, is aimed at greatly extending the length of time over which many patients suffering from chronic kidney failure can be treated.

Sponsored by the National Institute of Arthritis and Metabolic Diseases, the one-year research program is being carried out at the Columbus Laboratories of Battelle Memorial Institute.

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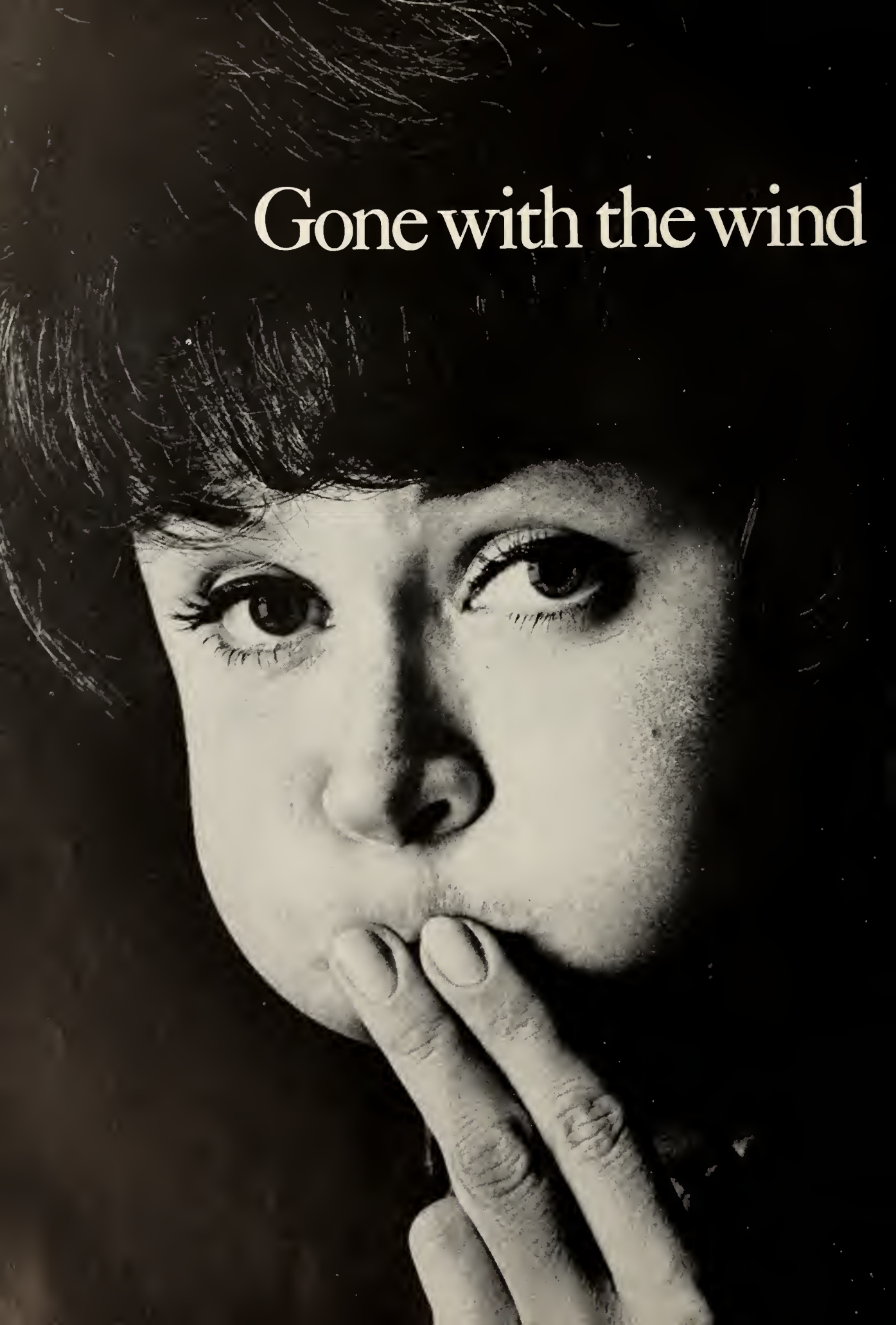
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A. C. Spath, Jr., R. A. Zimmermann
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: Suite 212, 4334 W. Central Ave., (419) 531-4981, R. E. Stallter


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The gas/acid group of disorders

"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

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The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

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when the patient prefers a liquid, select

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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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The Doctor

One of the doctor's most important roles is in education.

For his patients, the physician provides the facts, supplies the rationale, triggers the action for life-saving health practices. To his students, he passes on his knowledge and the benefits of his clinical experience. With his colleagues, he shares new information and concepts.

Assisting the doctor in his teaching role is a major function of our professional education program. Through medical conferences, films, exhibits, pamphlets, monographs and other publications, we provide him with the most important and current information on cancer.

If, as Henry Brooks Adams speculated, "A teacher affects eternity; he can never tell where his influence stops", the outlook is optimistic.



MDs in the News

Dr. Robert G. Page, dean of the Medical College of Ohio at Toledo, has been elected vice chairman of the Midwest-Great Plains region of the Association of American Medical Colleges. He will serve a two-year term. In the new post, Dr. Page also becomes a member of the executive council for the region which includes 25 medical schools and about 60 percent of all medical students in the United States.

An editorial in the October issue *Federation Bulletin,* publication of the Federation of State Medical Boards of the United States, pays tribute to the late Dr. Herbert M. Platter, former executive secretary of the State Medical Board of Ohio, who died in 1966. The luncheon at the annual business meeting of the federation is named in honor of Dr. Platter.

Dr. Herman K. Kellerstein, of Cleveland, was the subject of the cover feature for the October 19 issue of *Modern Medicine.* He is associate professor of medicine at Case Western Reserve University School of Medicine, associate physician at University Hospitals, and chief of the cardiology outpatient department.

Dr. Donald Dohn, of Cleveland, was installed as president of the Congress of Neurological Surgeons, at its 20th annual meeting in St. Louis. Dr. John N. Meagher, of Columbus, was named president-elect.

VA Hospital Admitting Procedure Modified

Veterans Administration hospitals have simplified procedures for admitting older veterans for treatment of conditions not related to military service, as a result of legislation approved by the President on October 22.

The new law removes, for certain groups of veterans, the requirement to certify that they are unable to pay for hospital care needed for conditions not related to military service.

(There is no such requirement for cases involving treatment of conditions resulting from or aggravated by military service.)

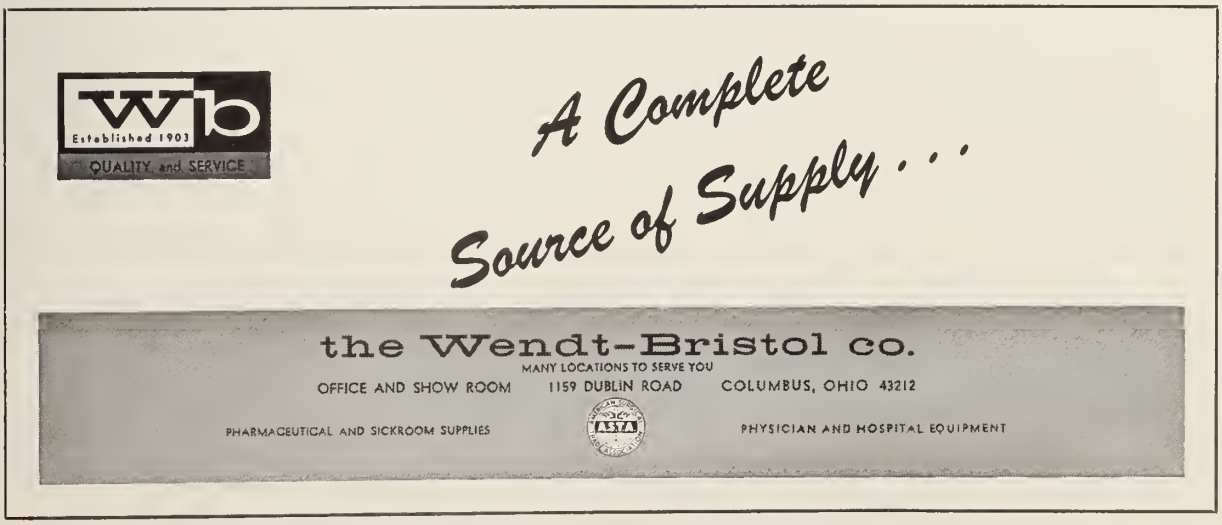
The requirement to sign the statement of inability to pay was removed for all veterans who have reached 65 years of age or older, and for veterans who receive VA pensions.

The new provision applies to all veterans 65 and over seeking hospitalization without regard to whether they serve during war or peacetime.

Veterans who receive increased compensation or pension on the basis of being housebound or in need of regular aid and attendance are authorized by the law to receive VA outpatient service as well as necessary medicines and drugs. (Outpatient dental care is not included.)

Prior to the new law, these benefits, with few exceptions, were extended only to veterans with service-connected conditions.

(The foregoing release was furnished to *The Journal* by the Veterans Administration Information Service.)



PUBLISHED TO REPLACE A PREVIOUS ADVERTISEMENT WHICH THE FOOD AND DRUG ADMINISTRATION CONSIDERED MISLEADING

The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus*. GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter.

Injectable Garamycin®

brand of gentamicin sulfate injection

Schering

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly Pseudomonas aeruginosa, Proteus and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS **Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.**

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

PACKAGING GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

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SCH-2620


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Clinical & Scientific Features







VOLUME 66 DECEMBER 1970 NUMBER 12

The Landacre Society

ROY A. FILLY*

THE LANDACRE SOCIETY was founded in memory of Francis L. Landacre, Ph.D., late professor of anatomy, by the members of the freshman medical class of 1955-1956 of The Ohio State University College of Medicine. It is the student research honorary society and selects its members from students who have shown both interest and excellence in the field of medical research. To qualify for membership, a student must be recommended for membership by the chairman of the department in which he carried out his investigations. The current members of the Society select the initiates from the list of nominees.

As mentioned, the purpose of the Society is to promote interest and excellence in medical research by undergraduate medical students. There are three principal means by which the members accomplish this purpose. First, that the members, by and large, continue their own research projects throughout their medical education providing an impetus and example to other students. Often the casual conversations on the wards between members and fellow students provide a stimulus which draws a student to embark on a research project.

In a more formal approach, the Society sponsors bimonthly research meetings at which time members present portions of their ongoing research to other student researchers and faculty advisors. Constructive criticism, suggestions for further studies,

*Fourth Year Medical Student and President of the Society for the 1969-1970 academic year. Dr. Filly graduated from The Ohio State University College of Medicine in June 1970.

Submitted May 7, 1970.

and occasional debate all provide further direction toward obtaining meaningful data.

Finally, the Society sponsors an annual scientific session at which time students present formally the data and conclusions derived from their research before a large gathering of faculty, house staff, students, and private physicians in the community. This session provides the students with an unusually fine opportunity to practice the rubrics of formal presentation, which many of them will do in the future before national medical meetings.

The quality of the following abstracts and the meaningful medical questions which these students undertook to answer demonstrate the success of The Landacre Society.

* * *

The Dynamics of an Intrinsic Pacemaker Mechanism

(First Place Winner)*

Mark J. Morton, Med. IV, and Willard S. Harris M.D.

Cardiac pacemakers (P) have an intrinsic mechanism that causes them to fire faster when stretched. Although stretch must change frequently with daily activities, the dynamic characteristics (D) of this response are unknown. To study the dynamic characteristics, we used, as an analogue of the denervated human right atrium and sinoatrial node, the isolated teleost (carp) ventricle (CV), a single chamber with a pacemaker but no sympathetic nerves. In the carp ventricle, the intrinsic pacemaker mechanism causes heart rate (HR) in the steady-state to vary directly with diastolic filling pressure (FP). In each of 32 perfused carp ventricles, filling pressure was varied from zero to 25 and back to zero cm. H_2O in graded steps and then continuously at three different rates of change (d(FP)/dt). When plotted against the filling pressure, the heart rate had hysteresis (H) that was clockwise at zero, absent at intermediate, and counterclockwise at fact d(FP)/dt. In contrast, ventricular pressure, volume, wall tension, and diastolic inflow rate had no hysteresis. Time plots of heart rate after step changes of filling pressure revealed two discrete dynamic characteristics: (1) transient damping, attributable to a parallel viscous element and causing heart rate at fast d(FP)/dt to lag behind steady-state heart rate; and (2) prolonged overshoot, consistent with a viscoplastic component and accounting for the static hysteresis. These dynamic properties may reside in the links between the carp ventricle wall and the pacemaker or in changes affecting the ionic flux of pacemaker cells. Thus the carp ventricle regulates its heart rate through an intrinsic pacemaker mechanism that responds dynamically to the rate, duration, and direction of change in the pacemaker stretch. It is postulated that this intrinsic mechanism, further modulated by superimposed neurohumoral influences, is a fundamental determinant of the heart rate in normal

*The first, second, and third place winners were given awards provided by Roche Laboratories, Division of Hoffman-La Roche Inc., Nutley, N.J.

* * *

Hyperkinetic Compulsive Syndromes in the Rat: The Mode of Action of Amphetamine and Apomorphine

(Second Place Winner)

James A. Thomas, Med. IV

Apomorphine (APO) and d-Amphetamine (dAM) will produce similar gnaw- (GC) and sniff-compulsion (SC) syndromes in rats. A common mechanism of action involving the dopamine (DA) receptor has been proposed *(Neuropsychopharm* 1:18, 1968). Rats were injected intraperitoneally with 10 mg per kg of apomorphine or d-Amphetamine (group A) and tested for gnaw compulsion, sniff compulsion, and locomotor activity (LA). Another group (B) was depleted of brain dopamine and noradrenalin (NA), and a portion of these (group C) were repleted with noradrenalin by dihydroxyphenylserine. Changes in dopamine and noradrenalin were confirmed fluorometrically. Group A rats showed greater than 60 percent increase in locomotor activity with gnaw compulsion or sniff compulsion following injection of apomorphine or d-Amphetamine before depletion. After depletion, group B rats injected with apomorphine showed an increase in locomotor activity with gnaw compulsion, while the action of d-Amphetamine was blocked.

Group C rats repleted with noradrenalin and injected with d-Amphetamine still showed no response, but responded with greater than 200 percent increase in locomotor activity with gnaw compulsion when given apomorphine, there was a decrease in locomotor activity, but with no change in gnaw compulsion. These data suggest that apomorphine acts directly on dopamine receptors, while the action of d-Amphetamine appears to be mediated by dopamine release. It has been well documented that acute amphetamine intoxication will induce in man a syndrome quite similar to an acute schizophrenic reaction, possibly by a similar mechanism as seen in hyperkinetic compulsive rats.

* * *

Tumor-Inhibitory Effects of Nonhomogeneous Magnetic Fields

(Third Place Winner)

Thomas R. Weber, Med. III

These experiments have evaluated the tumor inhibitory effects of a nonhomogeneous magnetic field, a previously unexplored method of controlling tumor growth. Mammary adenocarcinoma (H2712) mouse tumor cells, prepared by enzymatic digestion of the tumor, were exposed in vitro for 20 minutes to a 38 kilogauss magnetic field, field gradient 12 kilogauss per mm, and immediately injected into adult female C_3H/HeJ mice (one million cells per mouse). Control cells were handled in identical manner but were not exposed to the field. Mean life span of the mice receiving the treated cells was 18.0 + 2.0 days, while the mean control life span was 9.0 + 1.3 days ($p<.001$). In another experiment, barely palpable subcutaneous tumor (48 hours postinjection) in female C_3H/HeJ mice were exposed to the magnetic field for 20 minutes. Mean life span of the treated group was 18.3 ± 2.5 days, compared with a mean life span of the untreated mice of 7.9 ± 1.4 days ($p<.001$). Exposure of similar tumors for 20 minutes at 48 and 96 hours postinjection resulted in a mean life span of 20.1 ± 2.0 days, with a mean control life span of 9.4 ± 1.6 days ($p<.001$). The mechanism of tumor inhibition demonstrated in these studies is unknown, but possibilities include enzyme inhibition, alterations in cellular membrane function, and interference with DNA replication. The lack of apparent injury to the surrounding normal tissue and the ease with which field strength can be increased support the possibility of human application.

OTHER PAPERS PRESENTED

Human a-Globins as Immunosuppressives

Kenneth G. Morris, Med. II

* * *

Surface Morphology of Human Leukocytes

Thomas W. Michaelis, Med. IV

* * *

Determination of the Origin of "Leukocyte Control Factor" in the Spleen

William J. Lenz, Med. IV

* * *

A New In Vitro Measure of Anti-Lymphocyte (AGL): the Latex-Binding Lymphocyte (LBL) Assay

John J. Rinehart, Med. IV; Albert F. LoBuglio, M.D.; James Cerilli, M.D.; and Stanley P. Balcerzak, M.D.

* * *

The Dynamics of Strontium^{87m} Uptake in Fractures of Children

Richard L. Shaffer, Med. II, and Edward J. Eyring, M.D.

* * *

"The Student Investigator"

Norton J. Greenberger, M.D.

* * *

A High Resolution Radioisotope Scanning System that Indicates the Thickness of Tissue Overlying the Source

Joel E. Lichtenstein, Med. II

* * *

The Cycle of Morphologic Changes During Growth Phases of Mycoplasma Pneumoniae: A Scanning Beam Electron Microscopic Study

Gary M. Kramer, Med. IV; J. Dennis Pollack, Ph.D.; and Albert Klainer, M.D.

(Continued on next page)

PRESENTED BY TITLE

The Effect of Aluminum Oxide Implants in Rabbits

William N. Adkins, Med. IV, and Edward J. Eyring, M.D.

* * *

The Microcirculatory Effects of Low Molecular Weight Dextran and Dexamethasone in Hemorrhagic Shock

James N. Dreisbach, Med. III; Thomas S. Breza, Med. III and James W. Kilman, M.D.

* * *

In Vitro Common Carotid and Basilar Artery Reactivity in Hemorrhagic Shock

R. O. Dunker, Jr., M.D.; D. Yashon, M.D.; and W. E. Hunt, M.D.

* * *

The Effects of Xylocaine, Epinephrine, and Isoproterenol on Venous Blood Flow and Oxygen Consumption of the Hind Limbs of Dogs in Experimental Coarctation of the Thoracic Aorta

Joseph W. Fay, Med. II, and Marvin D. Shie, Med. II

* * *

Echographic Diagnosis of Pancreatic Lesions

Roy A. Filly, Med. IV, and Atis K. Freimanis, M.D.

* * *

An Evaluation of the Origin, Course, and the Termination of the Corticospinal Tract of the Opossum (Didelphis Virginiana)

Alan M. Fisher, Med. IV

The Relationship of Satellite Cell Hyperplasia to Neuronal Metabolic Street in Dorsal Root Ganglia

Dennis L. Karsh, Med. II

* * *

A Biomedical Engineering Evaluation of Criteria for Finger Joint Prostheses Design and a Proposed Endoprosthetic Design for the Metacarpalphalangeal Joint

Walter H. Kaye, Med. IV; William Campbell, Ph.D.; Ronald Berggren, M.D.; and R. J. Duran, M.D.

* * *

Metabolic Changes Associated with Administration of Antilymphocyte Serum in Mice

George F. Kish, Med. IV; Frank Lyons, Med. IV; and David H. Saunders, Med. IV

* * *

Experimental Studies in Polycystic Liver Disease

Edward L. C. Pritchett, Med. III

* * *

Verification of the Need for Donor Blood Agitation in Neonatal Exchange Transfusions

George R. Schuerger, Med. II; A. F. Roberston, M.D.; and I. J. Ertel, M.D.

* * *

Surface Morphology of the Early Hemostatic Reaction

Richard H. Shoop, Med. IV; and Stanley Balcerzak, M.D.

ERRATUM.—Referring to a footnote in the article, "Viewpoints: A Summary of a Symposium on Counseling the Cardiac on Work and Sex," page 1003, October 1970 issue of *The Journal,* it was erroneously stated that the symposium was held on December 3, 1970. The correct date of the symposium at Riverside Methodist Hospital in Columbus was December 3, 1969. —The Editor.

Experience with Percutaneous Transhepatic Cholangiography in a Community Hospital

Iradj Fazel, M.D., and Robert K. Finley, Jr., M.D.

PERCUTANEOUS transhepatic cholangiography is helpful in the differential diagnosis of jaundice. Jaundice appears as a result of:

1. Excessive bilirubin production (hemolytic jaundice);
2. Failure of liver to metabolize bilirubin (hepatitis);
3. Extrahepatic obstruction of biliary tree (stone, tumor).

Surgical treatment is helpful in the last group and of no help in the others. It is extremely important, therefore, for the surgeon to differentiate and select the surgical patients as early as possible.

Usually it is possible to make a correct diagnosis with an accurate history and physical examination together with a few well-selected laboratory tests. The patient's age, mode of appearance and degree of jaundice, presence or absence of pain, fever, chills, pruritis, and weight loss as well as color of urine and stools are helpful factors in clinical evaluation of icteric patients.

Laboratory tests including serum bilirubin, alkaline phosphatase, transaminase, prothrombin time, urine bilirubin, and bilirubinogen show characteristic changes in many cases and have important diagnostic value.

Unfortunately, in a small group of jaundiced patients, the cause of jaundice remains obscure and becomes a major diagnostic problem. Most of the laboratory tests are borderline and often confusing, and even liver biopsy is not diagnostic at times. Neither oral nor intravenous cholangiography will show the biliary tree when the serum bilirubin level is higher than 3 mg per 100 cc. It is in this group of patients that we believe percutaneous transhepatic cholangiography is a very helpful test.

Submitted March 2, 1970.

The Authors

• **Dr. Fazel, Dayton, is Resident in Surgery, Miami Valley Hospital.**

• **Dr. Finley, Dayton, is Director of Education, Department of Surgery, Miami Valley Hospital; a member of the Attending Staffs, Miami Valley and Kettering Hospitals, the Courtesy Staffs, Good Samaritan and St. Elizabeth Hospitals; and Consultant at the Dayton Veterans Administration Hospital.**

History

In 1921, before the advent of oral technique, Burkhardt and Muller reported on the possibility of visualizing the biliary tree by a percutaneous approach. Their needle was inserted into the gallbladder.[1]

In 1937, the procedure was described by Huard and Do-Xuan-Hop.[2]

In 1952, Carter and Saypol were able to visualize the biliary channels in a patient with obstructive jaundice by percutaneous puncture of the liver.[3]

Since then, there has been an increasing in-



FIG. 1. Percutaneous transhepatic cholangiography showed dilated right and left hepatic ducts and obstruction of common bile duct with nonopaque stone (case 1).



FIG. 2. Obstruction of common bile duct at junction of right and left hepatic ducts, characteristic of common bile duct stone (case 2).

terest in this subject which is reflected by numerous articles in the world literature.

Indications and Contraindications

Our indications for percutaneous transhepatic cholangiography are: (1) differential diagnosis of extra- and intrahepatic jaundice, and (2) determination of site, nature, and extent of obstruction preoperatively.

The only universally accepted contraindication of this procedure is abnormal blood clotting mechanisms. However, fever also has been suggested as a contraindication.[4]

Procedure

The test is done under local anesthesia with one percent Xylocaine. Blood clotting should be normal or corrected.

Patients are often scheduled for surgery following the test. We have not been giving broad-spectrum antibiotics to our patients; this has been recommended, however, because of frequent positive cultures (gram negative) obtained from bile in cases of obstructive jaundice.[5]

Patients are premedicated (Demerol 100 mg, phenobarbital 100 mg) one hour before the test. The procedure is performed in the x-ray department, and a television monitor screen has been used in all cases. We have used the subcostal approach in all our patients, as commonly recommended, although the intercostal route has been preferred by some.

In the last four cases, a plastic catheter has been used instead of a spinal needle; this seems to be safer, and the catheter may be left in place for further drainage. The patient is placed in a supine position on the x-ray table, and the right upper quadrant of the abdomen is prepped and draped surgically. The needle is inserted at a point 3 cm below and to the right of the xyphoid process of the sternum, aiming the needle medially and cephalad with 45° angle. With the patient in apnea, the needle is inserted 8 to 9 cm and the stylet is removed with the catheter left in place. At this time the patient can breathe gently.

The polyethylene catheter is connected to an empty syringe and, while continuous suction is maintained, the catheter is withdrawn slowly. Upon the appearance of bile in the catheter, it should be held in place and as much bile as possible aspirated to decompress the biliary tree.

At this time 2 to 3 cc of Conray (or other similar contrast agent) is injected and checked on the television to make sure that the catheter is in the proper position. We have found that 20 to 30 cc of the contrast material is sufficient to visualize the biliary tree.

After satisfactory pictures were taken, the contrast material and collected bile may be removed by a syringe. After removal of the catheter, the patient will be sent to the operating room or to the floor. If no bile was aspirated on the first attempt, the catheter would be reinserted at the same point with a slightly different angle and the same procedure repeated.

After four unsuccessful attempts, the test will be stopped and interpreted as negative or indicating the absence of dilated ducts. This has been true in all our negative cases.[5-8]

Complications

Complications of percutaneous transhepatic cholangiography have been rare. Bile leakage has been reported in 3.5 to 5 percent of cases and only seen in patients with complete obstruction due to cancer of pancreas.[9] Bleeding is another possible complication. Halligan with an experience of more than 3000 liver biopsies without complication states that this procedure should be routine in indicated cases.[10] No complications were encountered in this group.

Material

We performed the test in 14 patients, in nine it was successful, showing a dilated biliary tree. Of these nine cases, four patients had common duct stones; two patients had primary carcinoma of the biliary tree; one patient had metastatic carcinoma; one patient had a stricture of the common bile duct; and one patient had carcinoma of the pancreas. All these patients were operated on.

Of five unsuccessful cases, three patients had cirrhosis and two patients had hepatitis. The final diagnosis in these patients was made by laparotomy (in two cases) or autopsy (in one case) or long clinical follow-up. None of these patients had extrahepatic obstructive jaundice.

Case Presentations

Case 1. This 42-year-old white male patient was admitted with upper abdominal pain of three days' duration, jaundice, and low grade fever. He had slight hepatomegaly and moderate right upper quadrant tenderness. Serum bilirubin was 13.0 mg per 100 cc and alkaline phosphatase 9.3 units per 100 cc. Percutaneous transhepatic cholangiography showed dilated right and left hepatic ducts and obstruction of distal common bile duct with nonopaque calculus. This was confirmed at the time of the surgery (Fig. 1). The patient was dismissed on the 11th postoperative day (POD).

Case 2. This 55-year-old white male patient was admitted with mild epigastric pain of five days' duration and jaundice. Temperature was normal. He had minimal tenderness in the right upper quadrant. His liver was not enlarged. Total serum bilirubin was 11.0 mg per 100 cc and alkaline phosphatase 13.5 units per 100 cc.#. Percutaneous transhepatic cholangiography showed obstruction of extrahepatic biliary tree at the



FIG. 3. Common bile duct calculus with dilated proximal biliary system (case 3).



FIG. 4. Obstruction of common bile duct due to stone (case 4).



FIG. 5. Dilated right hepatic duct and nonfilling of left hepatic duct, most likely due to neoplasm (case 6).



FIG. 6. Tapered narrowing and complete obstruction of right hepatic duct, characteristic of tumor (case 7).

junction of right and left hepatic duct with no visualization of collecting system distal to this point, suggestive of common duct stone (Fig. 2). He was operated on, and a single stone was removed from the proximal common duct. He was dismissed on the 15th POD.

Case 3. This 64-year-old white woman was admitted because of attacks of right upper quadrant pain, nausea, and jaundice of 13 days' duration. She had no fever or hepatomegaly, but she did have right subcostal tenderness. Total serum bilirubin was 16.0 mg per 100 cc and alkaline phosphatase 20.8 units per 100 cc. Percutaneous transhepatic cholangiography showed obstruction of common duct at the junction of right and left hepatic duct, characteristic of common duct stone (Fig 3). A large stone was removed from the same area at the time of surgery. She was sent home on the 12th POD.

Case 4. This 60-year-old white woman was admitted with a history of cholecystectomy three years prior to this admission, upper abdominal pain of several months' duration, nausea, vomiting, and anorexia. She was slightly jaundiced but afebrile. Her liver was not enlarged, but she had mild right upper quadrant tenderness. Total serum bilirubin was 3.0 mg per 100 cc and alkaline phosphatase 23.1 units per 100 cc. Lactate dehydrogenase, serum glutamic oxaloacetic transaminase, serum glutamic pyruvic transaminase, and alkaline phosphatase levels were elevated. Percutaneous transhepatic cholangiography showed common duct calculus with dilated biliary tree (Fig. 4). Laparotomy confirmed the diagnosis, and she was dismissed on the 10th POD.

Case 5. This 65-year-old white man was admitted with mild jaundice, abdominal pain, and low grade fever of four days' duration. On physical examination, he had right upper quadrant tenderness, and his liver was palpable two fingerbreadths under the right costal margin. Serum bilirubin was 9.6 mg per 100 cc and alkaline phosphatase 26 units per 100 cc. Percutaneous transhepatic cholangiography showed dilated right and left hepatic duct with obstruction of common duct due to stone. This was proved at laparotomy. He was dismissed on the 12th POD.

Case 6. A 74-year-old white woman was admitted with a history of cholecystectomy five years prior to the admission, nausea, vomiting, intolerance to fatty food, jaundice, itching, and weight loss. Her liver was palpable 1½ fingerbreadths under the right costal margin on deep inspiration. No masses were palpable. Total serum bilirubin was 11.2 mg per 100 cc and alkaline phosphatase 21.8 units per 100 cc. Percutaneous transhepatic cholangiography showed dilated right hepatic ducts and nonfilling of the left hepatic duct and common duct, suggesting an obstructing lesion, most likely a neoplastic lesion at the junction of the right and left hepatic ducts (Fig. 5). Laparotomy revealed carcinoma of the common hepatic duct with obstruction of the right hepatic duct.

Case 7. A 55-year-old white woman was admitted with jaundice, history of vague epigastric pain, low grade fever, and weakness. On physical examination the abdomen was not tender; however, a right upper quadrant mass was vaguely palpable. Serum bilirubin was 6.5 mg per 100 cc and alkaline phosphatase 22.6 units per 100 cc. In percutaneous transhepatic cholangiography the left hepatic and common bile ducts were not shown, but near the expected entrance of the left hepatic duct, the right duct showed tapered narrowing and complete obstruction, suggesting a neoplastic lesion (Fig. 6). At the time of surgery, this was found to be poorly differentiated ductal carcinoma. The patient died on the seventh POD.

Case 8. This 63-year-old white woman with history of cholecystectomy two years prior to the admission, was admitted because of vomiting, jaundice, and itching. She had a history of two similar episodes lasting three to four days since her operation. Her temperature was normal. Her liver was palpable two fingerbreadths below the costal margin and was soft and non-tender. Serum bilirubin was 8.2 mg per 100 cc and alkaline phosphatase 35.0 units per 100 cc. Percutaneous transhepatic cholangiography showed a markedly dilated left hepatic duct and numerous filling defects representing stones. In addition, there was abrupt narrowing of the common bile duct at the proximal portion due to stricture (Fig. 7). The same abnormalities were found at the time of surgery, and a choledochoduodenostomy was performed. The patient was dismissed on the 14th POD.

Case 9. This 61-year-old Negro man was admitted because of mild jaundice of two days' duration and a history of gradual onset of right upper quadrant abdominal pain and weight loss (10 pounds) since three months prior to his admission. On physical examination, a slightly tender mass was vaguely palpable in right upper quadrant. Serum bilirubin was 9.0 mg per 100 cc and alkaline phosphatase 10.5 units per 100 cc. Lactate dehydrogenase, serum glutamic oxaloacetic transaminase, serum glutamix pyruvic transaminase, and alkaline phosphate levels were moderately elevated. Percutaneous transhepatic cholangiography showed obstruction of the common bile duct suggestive of tumor involvement (Fig. 8). At exploration, this was carcinoma of pancreas.

Discussion

Our experience with percutaneous transhepatic cholangiography indicates that it is a safe, easy, reliable test which provides the following information: (1) diagnosis of extrahepatic obstructive jaundice from hepatocellular jaundice; (2) differentiation of obstruction due to tumors from that due to calculus or stricture; and (3) accurate, valuable information regarding the exact site and extent of obstruction.

It has been suggested that the catheter be left in place for continuous drainage for a period of hours to days. Since all our positive cases have been operated on in the same day, we have not had an opportunity to try this.

As previously mentioned, complications are uncommon and include bile leakage and hemorrhage. Bile leak has been seen only in patients with complete biliary obstruction with carcinoma; and, since these patients are subjected to surgery, it would not cause any serious problem. If these patients, due to some special reason, could not be operated after the test, continuous drainage would eliminate this complication to a great extent. With normal or corrected blood clotting mechanism, hemorrhage is rare and of minimal concern.

We did not have any complications in our series. Also, in all positive cases, we were able to demonstrate the cause of obstruction (stone, stricture, or carcinoma) before laparotomy.

Summary

Percutaneous transhepatic cholangiography was performed in 14 jaundiced patients. This was done to differentiate obstructive from hepatocellular jaundice.

In nine cases we were able to demonstrate the site and nature of obstruction preoperatively. Five cases showed typical x-ray evidence of a



FIG. 7. Numerous filling defects representing stones in left hepatic duct. Also, abrupt narrowing of proximal common bile duct due to stricture (case 8).



FIG. 8. Markedly dilated bile-collecting system with appearance of tumor involvement (case 9).

stone, three showed the tapered narrowing of cancer, and one showed the location of a stricture with a stone. These findings were confirmed at surgery.

None of the five negative cases had extrahepatic obstruction.

There were no complications in this series.

We believe percutaneous transhepatic cholangiography is a safe, easy, and reliable test which provides the following information:

1. Differential diagnosis of extrahepatic obstructive from hepatocellular jaundice.
2. Accurate, valuable information regarding the nature, exact site, and extent of obstruction.

Generic and Trade Names of Drugs

Lidocaine—Xylocaine (Astra Pharmaceutical Products)

Meperidine hydrochloride — Demerol (Winthrop Laboratories and Breon Laboratories)

Sodium iothalamate — Conray (Mallinckrodt Pharmaceuticals)

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Self-Evaluation Quiz

1. A 40-year-old man with atrial fibrillation has the sudden onset of pain, coldness, and numbness of the right foot. On physical examination, the femoral pulse is normal but the right popliteal and pedal pulses are absent. Beginning immediately distal to the knee the skin is cold and anesthetic. He is unable to move the ankle or the toes.
   His management should include:
   (A) Heparin immediately followed by catheter embolectomy of the right superficial femoral artery within 24 hours
   (B) Heparin immediately, and catheter embolectomy of the superficial femoral artery within 4 to 6 hours
   (C) Observation for 24 hours with no specific treatment, and then reevaluation
   (D) Observation to determine the level of demarcation, followed by amputation of the right leg at the appropriate level.

[*From the Department of Surgery, The Ohio State University College of Medicine. The answer and reference are given on p. 1211 of this issue.—Ed.*]

Hypertension and Adrenal Cortex Disease

A Review of 100 Autopsied Cases

Robert N. Ludwig, M.D.

THERE IS considerable debate concerning the incidence of primary aldosteronism today. Since Conn's[1] revision of the criteria for the diagnosis with the inclusion of normokalemic subjects, it was estimated that primary aldosteronism may account for as much as 20 percent of all essential hypertension. This estimate was based on Shamma's[2] finding of adrenal cortical adenomas in 20 percent of hypertensive patients autopsied as compared with adenomas in 1.8 percent of normotensives. Earlier investigators[3,4] found adenomas in five percent and 7.4 percent of hypertensives, respectively. The significance of the high incidence of adrenal adenoma in hypertension remains obscure.

With the knowledge that normokalemic primary aldosteronism may be an early manifestation of the syndrome in which classic hypokalemic alkalosis later develops, the question arises as to what patient merits the extensive investigation necessary to make the diagnosis. This, unfortunately, is quite difficult to obtain in the average general hospital lacking facilities for a reliable renin assay or a metabolic ward. Still, a great many clinical tests involving the response of the renin-angiotensin-aldosterone system to a variety of stimuli have been devised.

In review, the cells of the zona glomerulosa of the human adrenal cortex produce aldosterone, a potent sodium-retaining mineralocorticoid which plays an important role in blood pressure regulation. Sodium restriction results in contraction of the extracellular volume. This is a stimulus to the juxtaglomerular cells in the kidney to release renin. Angiotensinogen, an α_2-globulin produced by the liver is converted to angiotensin I in the presence of renin. Angiotensin I, a decapeptide, is acted on by a converting enzyme, and the active octapeptide, angiotensin II, is generated. Angiotensin II stimulates the adrenal cortex to secrete aldosterone. When the extracellular volume is expanded, a fall in renin release occurs, resulting in lowered aldosterone levels.

As shown by Conn,[5] some tumors of the adrenal cortex are autonomous in their production of aldosterone, resulting in a supression of renin release from the juxtaglomerular cells, and this finding is the basis for the diagnosis of primary aldosteronism. As the disease progresses, renal potassium wastage occurs, and after a period of time, hypokalemic alkalosis may result. The combination of hypertension, hypokalemia, and increased aldosterone may be due to secondary aldosteronism in renovascular and malignant hypertension as well. Therefore, differential diagnosis is not always easy.

The strict preoperative criteria for suspected

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primary aldosteronism are excessive secretion of aldosterone and subnormal-to-absent plasma renin activity.[6] These tests are difficult to obtain and other methods of making the diagnosis have been investigated.

In this regard, some of the responses to various stimuli are reviewed. Thiazides will produce significant hypokalemia in patients with primary aldosteronism more readily than in others, and this is the basis of a screening test.[7] It is suggested that all patients with thiazide-induced hypokalemia be investigated for primary aldosteronism. The infusion of angiotensin will elicit a greater pressor response in those with essential hypertension and primary aldosteronism than in patients with renovascular hypertension.[8] This can be explained by a precedingly low angiotensin level in the former group and normal or slightly elevated angiotensin activity in renovascular hypertensives.[7,9] In primary aldosteronism, the plasma renin activity cannot be elevated above zero by sodium restriction as contrasted with the normal response of a marked increase.[5] Spironolactone, similarly, will not cause plasma renin activity to rise in primary aldosteronism, when sodium has been restricted.[5] Patients with primary aldosteronism, when given a salt load after a period of sodium restriction, respond with small changes in aldosterone secretion and an increased renal potassium loss, as contrasted with normal patients who respond with a marked reduction of aldosterone release but only minimally increased potassium loss.[6] The diagnosis of primary aldosteronism is based on these responses. Without a readily available means of renin assay and strict metabolic control, the diagnosis is difficult to make.

Material and Methods

With this information in mind, should all essential hypertensives who develop thiazide-induced hypokalemia be evaluated for primary aldosteronism? Is the incidence of the disease as high as 20 percent? Are many potentially surgically curable patients being overlooked? To provide information with which we could discuss these questions, we decided to review the autopsy protocols of 100 hypertensive and 100 normotensive patients from Mount Carmel Hospital, Columbus, Ohio. Only those patients admitted to the hospital were included. The diagnosis of hypertension was confirmed in all cases by the demonstration of hypertensive heart disease, ie, increased heart weight and concentric hypertrophy of the left ventricular wall in the absence of valvular disease. Consecutive autopsies were included and covered deaths from 1962 to 1967. A control group was matched for age and sex with the hypertensive group. The hospital records for the hypertensive group were also reviewed.

Results

Age and Sex.—There were 60 males and 40 females; the ages ranged from 16 to 88 years. The age distribution is shown in Table 1.

Table 1. Age Distribution

Under 40 Years	1	From 60 to 69 Years	25
From 40 to 49 Years	6	From 70 to 79 Years	44
From 50 to 59 years	8	From 80 to 89 Years	16

Blood Pressure.—The blood pressures recorded were taken from the admission physical examination. As some patients presented in shock and others in hypertensive crises, these pressures covered a wide range (Table 2). This distribution reveals that most patients had their blood pressure well controlled, with 85 percent having a diastolic pressure less than 100 mm. Hg.

Table 2. Range of Blood Pressure

Systolic (mm. Hg.)		Diastolic (mm. Hg.)	
<150	19	<90	30
150 to 199	50	90 to 119	55
200 to 250	24	120 to 149	9
>250	7	150 to 199	6

Arteriolonephrosclerosis was present in 93 percent of the patients although these changes varied from very mild to very severe in nature.

Serum potassium levels had been determined in 65 patients during hospitalization. The first serum potassium determination after admission was recorded, and these ranged from 3.0 mEq/liter to 10.0 mEq/liter. The normal range for the laboratory is 4.0 to 5.5 mEq/liter. Twenty-one (32.5 percent) were below normal, 41 (63 percent) were within the normal range, and three (4.5 percent) were elevated.

Associated lesions.—Each autopsy protocol was carefully examined in light of the clinical history to determine, wherever possible, any organic lesion that might be etiologically responsible for the hypertension. Special consideration was given to disease of the renal parenchyma and drainage system, the renal arteries, and the adrenal glands. The results are summarized in Table 3. One or more lesions were demonstrated in 40 patients.

Adrenal cortical enlargement.—This ranged in description from minimal nodular cortical hyperplasia to solitary adenomas measuring 18 mm

Table 3. Associated Lesions

Renal Lesions	
A. Parenchymal Disease of Kidney:	
1. Chronic pyelonephritis	8
2. Arteriosclerotic contracted kidney	2
3. Malignant hypertension	1
4. Glomerulonephritis	2
5. Nephrocalcinosis	1
B. Renovascular Occlusive Disease	14
C. Obstructed Drainage	3
Adrenal Enlargements	
A. Nodular Cortical Hyperplasia	9*
B. Solitary Cortical Adenomas	7*

*Seven of the total 16 showing adrenal enlargements, also had renal lesions.

in diameter. Of those showing adrenal cortical hyperplasia, the thickest cortex was 5 mm. The adenomas ranged in size from 7 mm to 18 mm. These patients are summarized in Table 4.

Control.—As a control, the autopsy protocols of 100 normotensive patients without evidence of hypertensive heart disease, matched for age and sex with the hypertensive group, were also studied. Of these, nodular cortical hyperplasia was described in six, and discrete adenomas were found in two more (10 mm and 20 mm in diameter).

Discussion

This study reveals that 31 percent of the hypertensive group had demonstrable renal parenchymal or renovascular lesions, and aside from adrenal cortical enlargement, essentially no other lesions (such as pheochromocytoma, coarctation of the aorta, brain tumor, etc.) were found. Males exceeded females with a ratio of 3:2. Most hypertensives died in the seventh and eighth decades. Arteriolonephrosclerosis to some degree was a common finding, being present in 93 percent. Blood pressures were essentially well controlled. Almost one third of the patients had low serum potassium levels on admission to the hospital, which may be attributed to thiazide therapy for the most part. Only one patient had the typical pathologic changes of malignant hypertension, while seven had clinical uremia.

Sixteen percent of the hypertensive group was found to have adrenal enlargement (hyperplasia in 9 percent, adenoma in 7 percent) as compared to 8 percent of the control group. No cases of primary adrenal carcinoma or Cushings disease were found. Since primary aldosteronism has been reported in hyperplastic adrenals without adenoma formation, these cases were included in the discussion.[10]

One cannot reliably conclude that enlarged adrenals, when present, are responsible for the hypertension even though this association has been alluded to above. We must remember that an autopsy study offers little in the way of physiologic information. Kaplan[11] studied adrenal adenomas obtained at autopsy and at surgery and found that the content of aldosterone, corticosterone, and cortisol in the adenomas obtained at autopsy was

Table 4. Adrenal Cortical Enlargement

Adrenal Cortical Hyperplasia

Number	Age	Sex	Serum K (mEq/L)	Blood Pressure	Associated Lesion
1	77	Male	Not determined	160/70	None
2	76	Male	Not determined	190/100	None
3	81	Male	4.3	180/60	None
4	48	Male	3.4	174/80	Nephrocalcinosis
5	65	Female	4.5	240/160	Malignant hypertension, uremia
6	74	Male	Not determined	220/110	Renal artery occlusion
7	76	Female	4.2	150/70	None
8	69	Female	4.7	240/130	None
9	56	Female	3.9	180/120	Contracted right kidney

Adrenal Cortical Adenoma

Number	Age	Sex	Serum K (mEq/L)	Blood Pressure	Associated lesion
1	74	Male	4.5	190/90	None
2	61	Female	Not determined	240/140	None
3	56	Male	Not determined	170/80	None
4	81	Male	3.9	158/74	None
5	78	Male	Not determined	120/80	Right, renal artery stenosis
6	75	Male	10.0	128/68	Uremia, chronic pyelonephritis
7	68	Male	Not determined	124/100	Right, renal artery stenosis

similar in both hypertensive and normotensive persons, and was much less than in those obtained from adrenalectomy of patients with primary aldosteronism. He suggests that most adrenal cortical adenomas found in patients with essential hypertension do not produce aldosterone.

The high incidence of renal and renovascular occlusive disease found in this study raises the question of secondary aldosteronism resulting in adrenal enlargement. Four of the nine patients with hyperplasia had associated findings of renal parenchymal and renovascular disease, as did three of the seven with adenomas. Of the total 16 patients with adrenal enlargement, only nine existed in the absence of these associated findings (except nephrosclerosis), and of these, only four were adenomas.

Conclusions

The incidence of primary aldosteronism is probably not as high as previously suspected. Adrenal cortical hyperplasia was found in 9 percent of all hypertensive patients, 7.2 percent with essential hypertension, 13 percent with renal parenchymal and renovascular lesions, and 6 percent of controls. Adrenocortical adenomas were present in 7 percent of all hypertensive patients, 5.8 percent with essential hypertension, 10 percent with renal parenchymal and renovascular lesions, and 2 percent of controls. In the absence of anatomic renal lesions, adrenal enlargement occurred in 9 percent with hypertension and 8 percent of controls.

These results suggest that few, if any, primary aldosterone secreting adrenal enlargements were overlooked in a review of autopsied cases spanning almost five years, at a general hospital. About one third of all hypertensives admitted to a general hospital may be expected to show thiazide-induced hypokalemia. Evaluation of all of these patients for primary aldosteronism would not be very rewarding.

Summary

Primary aldosteronism due to autonomously functioning adrenal cortical enlargement (nodular cortical hyperplasia or solitary adenoma) is a surgically curable cause of hypertension and is estimated to account for up to 20 percent of "essential" hypertension. Thiazide-induced hypokalemia may be a clue to the diagnosis. however, its confirmation rests on demonstration of low or absent plasma renin levels, a test not obtainable in the average hospital laboratory.

In order to further define the relationship between adrenal cortical enlargement and essential hypertension, the hospital records and autopsy protocols of 100 hypertensive patients and 100 normotensive patients were examined. Of the hypertensive group, arteriolonephrosclerosis was present in 93 percent, hypokalemia in 32 percent, and renal lesions in 31 percent. Adrenal cortical enlargement was found in 16 percent (adenoma 7 percent, hyperplasia 9 percent), however, only 9 percent existed in the absence of renal disease. There was nodular cortical hyperplasia in 6 percent and adenomas in 2 percent of the normotensive group.

The high incidence of renal parenchymal and renovascular disease found in this study suggests that secondary aldosteronism could account at least in part for the adrenal enlargement. In the absence of anatomic renal lesions, the incidence of adrenal enlargement in the hypertensive group was not significantly greater than in the normotensive group. We conclude: (1) Far less than 20 percent of essential hypertension is due to primary aldosteronism. (2) Evaluation of all hypertensive patients who show thiazide-induced hypokalemia for primary aldosteronism would not be rewarding. (3) More attention should be given to uncovering renal lesions which may be correctable causes of hypertension.

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Pulmonary Function Following Pulmonary Embolectomy for Massive Pulmonary Embolism

Case Report

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PULMONARY EMBOLECTOMY with the aid of cardiopulmonary bypass is firmly established in the emergency treatment of patients with life-threatening, acute, massive pulmonary emboli.[1-4] Controversy exists, however, concerning the role of pulmonary embolectomy in patients with acute pulmonary emboli associated with adequate cardio-respiratory compensation and in patients with chronic pulmonary emboli or pulmonary artery thrombosis. The primary basis for evaluation of treatment has been patient survival and relatively little attention has been given to a comparison of the long-term effects of operative and nonoperative treatment on pulmonary function. The rationale for nonoperative therapy is largely based upon the concept of spontaneous resolution of pulmonary emboli by intrinsic fibrinolytic mechanism[5-9] although resolution is usually incomplete[9,10] and significant respiratory dysfunction and pulmonary hypertension are commonly seen in patients with long standing recurrent pulmonary emboli.[11] In addition, marked reductions in pulmonary surfactant, loss of lung volume,[12,13] and impaired lung mechanics and respiration[10,14] are commonly seen after experimental pulmonary embolism and often persist after embolectomy. In view of these observations, it is evident that pulmonary emboli may produce significant acute and chronic impairment of pulmonary function,[11] and the preservation of lung function should be given greater consideration in the management of these patients particularly when there is preexistent pulmonary disease. Relatively little information is available, however, concerning pulmonary function in patients treated by operative and nonoperative means, and the final determination of ideal therapeutic technics awaits critical evaluation of the functional result of treatment as well as mortality considerations.

In the present report pulmonary function was examined in a patient with a life-threatening massive pulmonary embolism and for an extended period following successful pulmonary embolectomy.

Patient Summary

A 43-year-old man was admitted to The Ohio State University Hospital with cramping abdominal pain, nausea, and vomiting. Vagotomy and pyloroplasty had been performed one year previously for duodenal ulcer. Otherwise, he had enjoyed good health and worked at heavy labor without difficulty. The diagnosis of small bowel obstruction secondary to adhesions was established and, on October 26, 1966, he underwent celiotomy with surgical lysis of adhesions. His recovery was uneventful until the seventh postoperative day, when he experienced acute dyspnea and syncope.

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On examination, he was apprehensive, cold, clammy, and sweating with an irregular pulse rate of 170 beats per minute, a respiratory rate of 28 per minute, and an arterial blood pressure of 45/20 mm.Hg. The electrocardiogram showed atrial fibrillation which was not converted by carotid sinus massage. There was no evidence of myocardial infarction. Treatment included the administration of oxygen, digitalis, and intravenous vasopressors during which arterial blood pressure rose to 90/70 mm.Hg. A chest x-ray showed elevation of the right hemidiaphragm and decreased vascularity of the right lung. Pulmonary photoscan (Fig. 1) was diagnostic for occlusion of the right main and left lower lobe pulmonary arteries. A pulmonary arteriogram (Fig. 2) demonstrated complete obstruction of the right main pulmonary artery, left lower lobe artery, and several small branches to the left upper lobe. Because of the continued requirement for vasopressors, a pulmonary embolectomy was performed with the aid of total cardiopulmonary bypass. A period of approximately four hours elapsed between the onset of symptoms and operation. Arterial blood studies immediately prior to operation and before and during artificial ventilation with 100 percent oxygen are shown in Table 1. Large thrombi were removed from the main pulmonary artery and propagated thrombi were extracted from the radicals of the right and left pulmonary arteries. The lungs were massaged from the periphery centrally until no additional thrombi were retrieved. The patient was removed from cardiopulmonary bypass with satisfactory cardiovascular function and the infrarenal vena cava was ligated through a right flank incision. Serial arterial blood gas studies obtained throughout the postoperative period are summarized in Table 1. He was placed in an oxygen tent postoperatively, but because of arterial oxygen desaturation and labored respirations, a tracheostomy was performed and a volume controlled respirator (Emerson) was employed. Oxygenation thereafter was satisfactory and, 24 hours later, the respirator was discontinued and the patient was placed in an oxygen tent. Ventilation was adequate while the patient was maintained in this setting but significant arterial desaturation occurred in room air during the first three weeks postoperatively, after which arterial blood gas levels gradually returned to normal (Table 1).

Anticoagulation with heparin was maintained for three weeks postoperatively and then long-term anticoagulation with Coumadin was employed. Standard pulmonary function determinations were obtained two weeks after operation and repeated at regular intervals over the following eight months (Table 2). These studies indicate a moderate to severe restrictive pulmonary functional impairment. The pulmonary photoscan, and



Fig. 1. Preoperative pulmonary photoscan showing nonperfusion of right lung and reduced perfusion of left lower lobe.

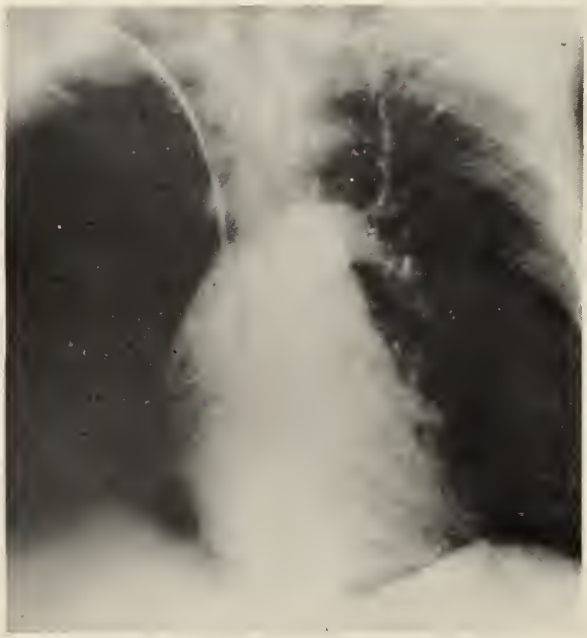


Fig. 2. Preoperative pulmonary arteriogram demonstrating complete obstruction of the right pulmonary artery, left lower lobe artery, and small branches to left upper lobe.

TABLE 1. Serial Pre- and Post-pulmonary Embolectomy Determinations of Arterial Blood Gas Tensions and pH in a Patient with Acute Massive Pulmonary Embolism.

Time	pO_2	pCO_2	pH
Preoper. Room air	60	33	7.34
Immediately preoper.			
Respirator — 100% O_2	200	43	7.40
Immediately postoper.			
Respirator — 100% O_2	220	48	7.35
Room air	72	42	7.38
1st postoper. day			
Respirator — 50% O_2	122	30	7.58
Room air	58	38	7.42
O_2 tent	78	43	7.42
2nd postoper. day.			
O_2 tent	106	37	7.50
6th postoper. day			
Room air	60	35	7.50
O_2 tent	97	39	7.48
9th postoper. day			
Room air	74	40	7.46
13th postoper. day			
Room air	80	35	7.48
29th postoper. day			
Room air	95	37	7.42

TABLE 2. Serial postembolectomy pulmonary function studies.

Time post-operatively	Maximum Voluntary Ventilation (% of expected)	Vital Capacity (% of expected)	1 sec. Functional Vital Capacity (% of expected)
2 weeks	139	52	50
3 months	124	62	67
5 months	119	65	62
8 months	113	66	66



FIG. 3. Pulmonary photoscan four weeks postoperative indicating relatively normal perfusion of the right lung but a suggestion of several areas of hypoperfusion in left lung.

arteriogram obtained four weeks after operation are demonstrated in Figures 3 and 4 respectively. The pulmonary arteriogram showed restoration of blood flow. However, there was a suggestion of decreased perfusion of both lungs. Photoscan indicated essentially normal perfusion of the right lung, but there were several areas in the left lung which were hypoperfused. Blood pressures in the main pulmonary artery were 35/5 mm.Hg. He improved progressively and, on December 8th, he was discharged on Coumadin anticoagulation. The patient has done well during the 3½ years since discharge from the hospital and has returned to his employment at vigorous physical labor. However, he complains of shortness of breath with exertion which was not present before the pulmonary embolus.

Comment

The arterial hypoxemia observed in this patient immediately following pulmonary embolism is, of course, what one would expect. However, the persistence of a low arterial pO_2 which slowly



FIG. 4. Pulmonary arteriogram one month postoperative demonstrating restoration of blood flow to previously obstructed vessels but suggested hypoperfusion of parenchyma of both lungs.

returned to normal over a four-week period, is somewhat surprising. Greenfield et al[10] showed a similar defect of blood oxygenation in dogs following pulmonary embolectomy for experimental pulmonary embolism. They postulated that it might be the consequence of operative lung trauma associated with the manipulation necessary to evacuate distal thrombi or more likely the persistence of propagated thrombi in the small vascular radicles. Another, and probably more important, consideration is ischemic injury to the alveolar-capillary complex distal to the obstructing embolus producing significant tissue damage without gross infarction. On the other hand, all or any combination of these factors may be etiologic in individual patients. In any case, the precise pathophysiologic mechanisms have not been determined, and the development of optimal therapy is dependent upon a more complete understanding of the processes involved.

The postoperative standard pulmonary function studies consistently indicated restrictive pulmonary disease. Although preoperative pulmonary function studies were not obtained, it is thought to be of significance that the patient had previously worked at hard labor without respiratory distress. Following his recovery, however, and in spite of an apparent return of strength and vigor, he continues to complain of shortness of breath with exertion. Marable et al[15] employed standard pulmonary function evaluations in patients recovering from pulmonary embolisms of varying severity and found little if any abnormality. However, they emphasized the relative insensitivity of these determinations and the usual great pulmonary reserve which complicates interpretation and limits their value.

The concept of spontaneous resolution of pulmonary emboli by intrinsic fibrinolytic mechanisms represents one of the strongest arguments in favor of nonoperative treatment. However, although spontaneous resolution of pulmonary emboli has been shown to occur, many investigators have concluded that complete resolution is unusual, and Paneth[16] states that he doubts it ever occurs.

The delayed recovery of arterial oxygenation and the impaired pulmonary function observed in this patient may be interpreted in many ways. One might reason that, shortly after an embolus, ischemic pulmonary parenchymal damage occurs rapidly and is benefitted little by embolectomy. On the other hand, the extensive experience with peripheral vascular surgery indicates that removal of the mechanical blockage by the offending embolus prevents propagation of thrombus and permits tissue recovery if performed early. The latter concept appears most sound physiologically and one might conclude that, when pulmonary embolus is strongly suspected, embolectomy should be performed as soon as possible to minimize ischemic lung damage. In this patient, there was a delay of four hours from the time of pulmonary embolism to operative correction. This delay can be substantially reduced thus improving the functional result. We recognize that few conclusions can be drawn from a single patient. However, the similarity of the observed alterations to reported experimental results supports their validity. In patients with normal lungs, treatment of pulmonary embolism which allows damage to pulmonary function may be acceptable since pulmonary reserve is extensive; however, the choice of therapy in patients with compromised pulmonary function should be aimed at the preservation of as much lung function as possible. It should be emphasized that pulmonary embolectomy with the aid of cardiopulmonary bypass is a relatively simple procedure which can be performed with acceptable safety. The mortality statistics that have been reported are largely a reflection of emergency operations performed on patients with massive pulmonary emboli often resulting in the necessity for cardiopulmonary resuscitation associated with hypoxia, shock, and cardiac arrest. Pulmonary embolectomy in patients with significant acute emboli but compensated cardio-respiratory function could be expected to be attended by a mortality and morbidity comparable to that attained in the operative repair of simple atrial septal defects and uncomplicated pulmonary valvular stenosis. Contraindications to operation in these patients would then include only those concommitant accompanying medical and surgical conditions which would obviate any surgical procedure. It seems reasonable to suggest that early pulmonary embolectomy be considered, not only in those patients in whom

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survival seems unlikely without embolectomy but also in patients in whom embolism has been documented by angiography indicating its accessibility by pulmonary embolectomy. Perhaps any major lobar or bilobar occlusion should be included in this category, particularly in patients with previously established impaired pulmonary function. In any case, patients treated by either operative or nonoperative means should undergo extensive clinical study to evaluate the effects upon pulmonary function and determine the efficacy of the therapeutic technic employed.

Summary

A patient with acute, massive, life-threatening pulmonary embolism underwent successful embolectomy. A correlative analysis of arterial blood gases, pH, and pulmonary function data indicated substantial preoperative and early postoperative impairment of pulmonary function, which was felt to be the result of pulmonary parenchymal ischemia. Pulmonary function improved gradually during the month after operation. However, some permanent impairment was evident. The results indicate that pulmonary emboli may produce substantial acute and chronic pulmonary functional impairment and operative and nonoperative therapy should be reevaluated with a view toward preserving pulmonary function.

Generic and Trade Name of Drug
Sodium warfarin — Coumadin (Endo Laboratories)

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Self-Evaluation Quiz

2. A 28-year-old man was hospitalized because of diarrhea, weight loss, and abdominal pain. Examination of the anus and rectum showed a fistula-in-ano and edema of the rectal mucosa with a few small "punched out" ulcers. The barium enema showed narrowing of the lumen of the colon with edema and ulceration of the mucosa. A diagnosis of ulcerative colitis was made and proctocolectomy and ileostomy were performed. Postoperatively, the patient developed multiple ileocutaneous fistulae. Roentgenograms after a barium meal showed edema and ulceration of the mucosa of several portions of the ileum with normal mucosa between the diseased areas.

   The patient's disease was most likely:

   (A) Amebiasis
   (B) Ulcerative colitis with a postoperative complication of ileocutaneous fistula
   (C) Granulomatous enteritis (Crohn's disease) of the small and large intestine
   (D) Periarteritis nodosum

[*From the Department of Surgery, The Ohio State University College of Medicine. The answer and reference are given on p. 1211 of this issue.—Ed.*]

Clinical Management of Patients with Prosthetic Valves

Morton Korn, M.D.*

REPLACEMENT of diseased heart valves has created a large population of patients with prosthetic valves. A prosthetic valve may be inserted in the mitral, tricuspid, or aortic position, or in any combination of these. Artificial atrioventricular valves usually consist of a caged plastic disc or ball; the most commonly used mitral prosthetic valve in our institution is the Beall valve. The cloth-covered Starr-Edwards ball valve has become the most widely used aortic valve prosthesis. The clinical problems presented by patients with the varied types of prosthetic valves are similar.

General Considerations

Patients with prosthetic valves require close, careful follow-up. It has been our practice to keep patients in the hospital for at least two weeks postoperatively. By this time there should be no residual problems relating to fever, infection, unrecognized leaks around the prosthesis, hemolysis, post-pericardiotomy symptoms, or anticoagulation. If the level of anticoagulation is adequate and the anticoagulant dosage has been stabilized, we recommend that the patient be seen one week after discharge. Thereafter, the patient should be seen monthly for the next six months. At six months, we urge recatheterization of all patients with prosthetic valves. It has been our experience that most patients readily accept this and that a great deal of significant information can be obtained relevant to the function of the prosthesis, the presence of valvular insufficiency, and the state of myocardial contractility.

Patients with a prosthetic valve should be encouraged to live relatively normal lives. We urge our patients to resume their full activities over a six-month period. Most patients appreciate general guidelines for resumption of activity; occasional patients ask for day-to-day activity schedules. The basic guideline which we set is gradual progression of activity to limits of tolerance. A reasonable social and sexual life is encouraged. We discourage patients from smoking and using alcoholic beverages, the latter because of difficulty which may be encountered in maintenance of prothrombin time control. Our patients are usually urged to remain on a one gram (or less) sodium diet. We suggest that our patients inform their dentists of the presence of their prosthetic valve.

Specific Considerations

There are several important specific aspects which are involved in the day to-day care of patients with prosthetic valves. First, each patient should have a thorough physical examination on each visit to his doctor. Great care must be paid to the quality of the prosthetic valve sounds. While it is beyond the scope of this paper to discuss the subtleties of prosthetic valve opening and closing sounds, suffice it to say that the physician should be aware of what any patient's prosthetic valve sounds like and must be alerted by any changes which occur in these sounds. It also behooves the

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Provided by the American Heart Association, Inc. and made available to *The Journal* by the American Heart Association-Ohio Affiliate, Inc.

physician to be aware of any regurgitant murmurs suggesting a paravalvular or valvular leak.

It is usually necessary to treat these patients with one of the cardiac glycosides. Many patients with prostheses are in atrial fibrillation and require glycosides for control of ventricular rate. With rare exceptions, we thus keep all of our patients on digoxin 0.25 to 0.5 mg. daily. Coincident with the use of digitalis, the physician must determine the serum potassium level at frequent intervals. If the patient is receiving diuretic therapy, we encourage the use of potassium chloride supplementation. Dietary intake is usually insufficient to maintain normal serum potassium levels in most patients taking even small doses of diuretics. We supplement the diet with 10 cc. of 10 percent potassium chloride three times a day, or one ounce of the sugar-free potassium chloride solution (20 mEq) three times a day. Potassium chloride tablets should not be used. The incidence of digitalis intoxication will be reduced in relative proportion to the physician's ability to maintain an adequate serum potassium level.

We have adopted the principle of permanent anticoagulation in all patients with mitral and tricuspid prosthetic valves. Formerly, we felt that a six-month period of anticoagulation was adequate; however, we have recently encountered a sufficient number of late emboli, even with the Beall valve, to alter our policy. On the other hand, we are anticoagulating the patients with cloth-covered aortic prosthetic valves for only six months, unless an embolic episode occurs in which instance permanent anticoagulation is used. Patients who are on anticoagulants must be aware of the fact that the coagulation mechanism has been disturbed by the medication. Such patients must call to their physician's attention any problems of oozing or bleeding. The use of aspirin must be avoided. We encourage all patients on anticoagulants to look at their stools periodically and to report any darkening.

The use of rheumatic fever prophylaxis in patients with prosthetic valves is a controversial subject. Many groups discontinue routine prophylaxis at an arbitrary age, usually 21. We have elected to continue all of our patients with known or suspected rheumatic heart disease on daily penicillin therapy. Erythromycin is used in the patient who is allergic to penicillin. It is critical that the principles of subacute bacterial endocarditis prophylaxis be applied to any patient with a prosthetic valve who is to undergo a dental or surgical procedure. This cannot be over-emphasized. We have seen bacterial endocarditis in patients who were not on appropriate prophylactic antibiotic therapy before a minor dental procedure. Our policy has been to adhere to the recommendations laid down by the American Heart Association*. For procedures involving the gastrointestinal and/or urinary tract, streptomycin is given in addition to penicillin.

It has been recently realized that all patients with prosthetic valves have some degree of hemolytic anemia. This is marked by elevated serum LDH, reticulocytosis, and hemosiderinuria. Two problems may emerge in association with the hemolytic anemia. First, these patients may become iron deficient because of the loss of iron in the urine. Second, increased erythropoiesis exaggerates the daily requirement for folic acid. It has therefore been our policy to treat all patients with prosthetic valves with both iron and folic acid as long as there is any evidence of significant hemolytic anemia. Fortunately, serious hemolysis usually ends within six months, as the valve becomes endothelialized. Because of severe hemolytic anemia, the occasional patient will have need for intermittent packed cell transfusion over the first three to four months following valve insertion.

The final point worthy of emphasis concerns routine follow-up with an electrocardiogram and chest x-ray every six months in all patients with prosthetic valves. The electrocardiogram serves as an index of heart rhythm and rate and calls attention to problems, such as digitalis intoxication, which can be missed clinically. The serial evaluation of heart size by chest x-ray is an important adjunct in evaluating the patient's progress.

The purpose of this paper has been to outline the general and specific therapeutic problems which may be encountered in management of the patient with a prosthetic heart valve. These patients offer both challenge and reward to the physician responsible for their management.

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*Management of Dental Problems in Patients with Cardiovascular Disease (EM 349), Prevention of Bacterial Endocarditis (EM 113B). Obtain from your local Heart Association.

Answers to Self-Evaluation Quiz

Page 1200 Question 1. (B)
Reference: Tarnaym, T. J.: Arterial Embolism of the Extremities: Experience with 62 Patients. *Arch. Surg.*, 99:615-618, 1969.

Page 1209 Question 2. (C)
Reference: Law, D. H.: Regional Enteritis. *Gastroenterology*, 56:1086-1110, 1969.

GUEST EDITORIAL

Tetanus Prophylaxis in the United States

DURING THE PAST CENTURY, concepts concerning tetanus prophylaxis have changed markedly. Approximately 100 years ago, tetanus prophylaxis consisted primarily of wound care. Today, in contrast, the approach is positive, in that the correct use of tetanus toxoid, the immediate and meticulous surgical care of wounds, the indicated injection of human tetanus immune globulin, and the use of emergency medical identification devices are emphasized. From the early part of the twentieth century, the American College of Surgeons, through its Committees on Trauma, has been active in developing tetanus prophylaxis and in endeavoring to help the medical profession in crystallizing its thinking about such prophylaxis.

In the United States, at the present time, emphasis is being placed upon not how *frequently* a routine tetanus toxoid booster should be given, but on how *rarely* a routine tetanus toxoid booster should be given. Tetanus toxoid has become one of the most effective antigens which have been developed. Too frequent and unnecessary doses of tetanus toxoid could result in unnecessary reactions to tetanus toxoid so that individuals would not ask their physicians for indicated routine booster doses.

Current research includes studies on the immunologic potentials of different tetanus toxoids, the optimum interval for a routine tetanus toxoid booster, and the maximum length of time at which an anamnestic response to toxoid is possible.

Tetanus immune globulin (human), known also as TIG(H) or human tetanus antitoxin, has been referred to by at least 25 other scientific or trade names in the literature and in advertisements. Since significant reactions to TIG(H) do not occur for all practical purposes, there has been a tendency to administer this antitoxin when it is not indicated and to forget that it must be obtained from human volunteers.

Simultaneous active-passive immunization with TIG(H) and toxoid is possible and should be practiced when necessary. Unusual indications for simultaneous administration of both TIG(H) and toxoid to the wounded are:

(1) Agammaglobulinemia.

(2) Recent exposure to radioactive substances.

(3) Recent exposure to immunosuppressive agents. Chloramphenicol is temporarily to be included in this group, for it has been noted that commonly employed therapeutic amounts of chloramphenicol to treat infections in man suppress the anamnestic response to tetanus toxoid.

It would indeed be a tragedy for a renal or cardiac transplant patient, who has had his immune mechanisms altered to prevent transplant rejection and who suffered a minor wound, to develop tetanus and to die since an administered toxoid booster did not produce the usual active antitoxin response and since the patient was not given TIG(H) in addition to toxoid!

All too frequently, the victims of trauma do not have on their person a proper emergency medical identification device. An incorrect belief that an injured person has had adequate prior tetanus toxoid immunization might result in giving only tetanus toxoid, when both it and TIG(H) were indicated, and might result in the patient developing tetanus.

During the past few years, the *Weekly Reports from the U.S. Public Health Service National Communicable Disease Center** in Atlanta, Georgia, emphasize that, with proper prophylaxis, tetanus is being diagnosed less frequently in the United States. According to the December 27, 1969, Weekly Report, for the first 52 weeks of the years during the period 1964-1968, there was reported a median of 233 cases of tetanus for the entire United States; for the first 52 weeks of 1968, there was reported 163 cases; and, for the first 52 weeks of 1969, there was reported 166 cases.

About a decade ago, President Kennedy predicted that man would be on the moon within ten years; his prediction was confirmed. *Hopefully, with the means available in the United States and in view of the figures quoted above, by 1980, tetanus will no longer occur in the United States, and will have become a disease of only historical significance.*

WESLEY FURSTE, M.D.
Columbus, Ohio
Guest Editor

Editor's Note: Dr. Furste's poster on tetanus prophylaxis has been translated into Spanish and has been distributed throughout Central and South America. —P.R.A.

Submitted March 17, 1970.

*In the July 4, 1970 *Weekly Report*, a change of name from National Communicable Disease Center to Center for Disease Control was announced.

Maternal Mortality Report For Ohio-1967*

By the OSMA Committee on Maternal Health

WITH A SENSE OF PRIDE, the Committee on Maternal Health publishes this THIRTEENTH Annual Report for the year 1967. The document is compiled and presented in compliance with a House of Delegates directive creating the Committee and subsequent follow-up action by the OSMA Council, January 16, 1954.[1]

Divided into *five* sections, the first division outlines *activities* of your Committee since its last report to The Council, February 22, 1970.[2] In the second part several Committee *projects* are described representing developments to fulfill its assigned functions, while the third portion contains a detailed *statistical* summary gleaned from the Ohio Study during 1967. Covering all 88 counties of Ohio, the data include not only hospitalized patients but those who "died at home." Part four summarizes and *discusses* the data and, finally, *recommendations* from your Committee are submitted based upon its experiences with "Maternal Health in Ohio."

Activities

Twenty-one members comprise the Committee, representing all eleven Councilor Districts of Ohio. Two new members were appointed to the Committee to replace faithful individuals required to resign with regret due to personal reasons. As this document goes to press, a third member will depart for a New England assignment, to be replaced in May 1971 by another specialist.

Adhering to provisions of the initial directive,[1] every attempt is made to have committee members represent the family physician, as well as specialists in obstetrics and gynecology, anesthesiology, pathology, and internal medicine, respectively.

Two meetings of the Committee were held in 1970 as this article is prepared; a most successful two-day meeting (the 52nd) was held at the Granville Inn, January 17 and 18. The 53rd meeting was convened July 12. Seventy-four cases were reviewed and classified by the Committee, using "Guiding Principles for Obstetric Care"[3] as a standard for "Ideal Care." In addition, an inter-member mail correspondence system was employed to complete various projects (see below).

By invitation, *three* Committee members (Brandeberry, Kretchmer, and Ruppersberg) participated in the program of the Sixth World Congress of Gynecology and Obstetrics (ACOG-FIGO), April 13 to 18, 1970 in New York City.

The Chairman presented three papers related to Ohio Maternal Mortality Studies at the Annual Meeting of the Texas Medical Association in Dallas, April 30 to May 3, 1970.

Quarterly, during 1970, the Committee continued sponsorship of the "Maternal Health in Ohio" column of *The Journal.* The third article (September issue) entitled "Heart Disease in Pregnancy" provided not only an excellent treatise on cardiac physiology during gestation, but also depicted data from the Committee's experiences with "Maternal Deaths Due to Cardiac Disease."

*A continuous state-wide Maternal Mortality Study is being conducted in Ohio by the Committee on Maternal Health of the Ohio State Medical Association, in cooperation with the Ohio Department of Health, and assisted by representatives of the various County Medical Societies of the state. Since work of the Committee is educational as well as statistical, summaries of some of the cases studied by the Committee, based on anonymous data submitted, are published in *The Ohio State Medical Journal* from time to time. Each presentation is brief but informative. It contains opinions of the Committee, based on the data submitted for review.

The latter was based upon the Committee's Scientific Exhibit at the OSMA Annual Meeting, May 11 to 15, 1970 in Columbus. This 1967 Report is the fourth in the series for 1970.

Projects

As cases are collected, studied, and classified by the Committee, information on each death is transferred to an IBM card. Thus, the data processing system continues to grow. From time to time the system is used to glean specific data and information for various educational programs. To date, 1375 cases are on IBM cards.

Currently, a subcommittee is making plans for the Committee's scientific exhibit to be displayed during the *1971 OSMA Annual Meeting.* Incidentally, at the Exhibit Booth, pertinent reprints and information will be furnished to visitors without charge. Among the pamphlets will be the first two of a series of "Maternal Health in Ohio, *Ready Reference Cards.*"

During the past year and a half, the Committee has worked diligently to prepare these brief "check lists," each concerning one of the more common (often fatal) obstetric complications. As a "project," this is considered one of the more important facets in the Committee's educational program.

Late in the summer, the Secretary and the Chairman held a conference with Dr. Winslow Basch (newly appointed head, Maternal and Child Health Division, Ohio Department of Health) and Mr. William Veigel (Vital Statistics Division, Ohio Department of Health); purpose of the preliminary meeting was to lay plans for a systematic (computer) method to cull out more completely, "maternal death cases" in Ohio. While present methods are appreciated as being fairly efficient, it is realized that each year some *maternal deaths* escape recording due to omissions in diagnosis and transcription.

The Committee continues liaison with well-established *County* Maternal Mortality Studies. Six of these operate annually, in Cleveland, Columbus, Cincinnati, Dayton, Toledo, and Akron; principally, they are supported by their respective Obstetric-Gynecologic Societies, in cooperation with the County Medical Societies.

In the adjacent column, the Committee presents statistics from The Ohio Study for the year 1967. Comparison with various past and future reports is facilitated by uniformity and a use of terminology and nomenclature prescribed in the *International Classification:*

Ohio Maternal Mortality Study Statistics for 1967

Total Live Births in Ohio, 1967		**185,204**
(Total Cases in files, 1955-1967		1375)
Total Cases Studied (1967)		74
Cases not studied due to lack of information		1
Undetermined		0
Maternal Deaths (Classified)		**52**
Non-white	10	
White	42	
Age:		
Teens	7	
20's	23	
30's	19	
40's	3	
Parity:		
Primigravidae	11	
Multiparae	37	
Unknown	4	
Place of Death:		
Hospital	43	
Home	5	
Other	4	
Type of Delivery:		
Not Recorded	1	
Operative	23	
Nonoperative (spontaneous)	16	
Not delivered	12	
Route of Delivery:		
Not recorded	2	
Vaginal	28	
Cesarean	9	
(antemortem)	9	
(postmortem)	0	
Laparotomy (ectopic preg.)	1	
Not delivered	12	
Case Classification: (when death occurred)		
Not known	0	
Group I (fr. concept to 20th wk.)	4	
Group II (fr. 20th wk. to 28 wk.)	2	
Group III (fr. 28th wk. through term)	6	
Group IV (postabortal, postpartum)	40	
Autopsies	46	
(includes 11 coroners' cases)		
Prenatal care: (apparent from data sheets)		
None	1	
Unknown or not reported	8	
Adequate	28	
Inadequate	8	
Excluded (ectopic preg. and abortion)	7	
Classification of preventability:		
Nonpreventable	13	
Preventable (avoidable factor)	39	
Patient responsibility (P_1)	12	
Personnel responsibility (P_2)	18	
Both P_1 and P_2	5	
P_3 (Misc.)	4	
Classification of Primary Causes of Death:		
Hemorrhage		**12**
Abortion, without sepsis	0	
Abruptio	1	
Afibrinogenemia	2	
Abruptio	2	
Am. fl. embolus	0	
Dead fetus	0	
Ruptured uterus	0	
Atony, uterine, postpartum	2	
Ectopic pregnancy (without sepsis)	2	
Laceration, extrauterine	0	
Placenta praevia	0	
Retained placenta	0	
Ruptured uterus (no afibrin.)	5	
Other	0	
High Risk Related: 2 Non-Related:		*6*

Infection		10
Abortion, alleged "criminal"	2	
Abortion, septic, spontaneous	1	
Up. resp. inf.	0	
Peritonitis	2	
Septicemia (puerperal sepsis)	2	
Septicemia (other)	2	
Other	1	
High Risk Related: 0 Non-Related: 6		
Toxemia		2
Acute yellow atrophy	0	
Hypertension, chronic (incl. hypertension with cerebrovascular hem.)	0	
Eclampsia	1	
Preeclampsia	1	
Puerperal toxemia, not specified	0	
High Risk Related: 1 Non-Related: 1		
Other		28
Amniotic fl. emb. (no hemorrhage)	6	
Anesthesia	2	
(general)	1	
(regional)	1	
Cardiac arrest	1	
Cardiac disease	4	
Cerebrovascular hemorrhage (no tox.)	2	
Drug poisoning	0	
Liver disease	0	
Lower nephron-nephrosis	0	
Pulmonary edema	1	
Pulmonary embolus	9	
Renal disease, chronic, unspecified	0	
Suicide	2	
Ulcerative colitis	1	
High Risk Related: 2 Non-Related : 12		

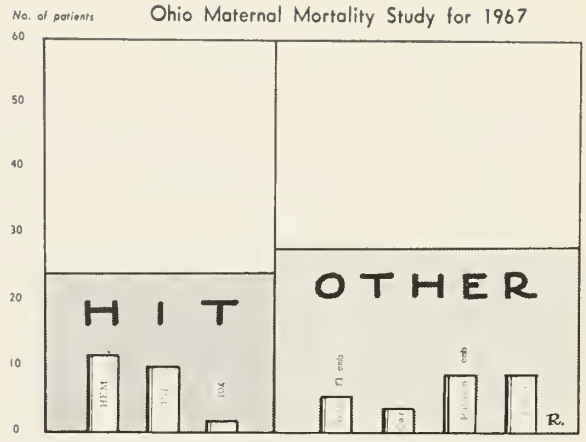


FIG. 1. Classification of primary causes of death, 52 maternal deaths for 1967.

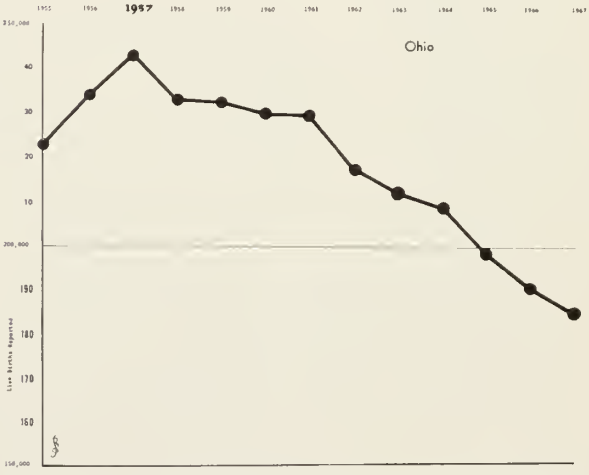


FIG. 2. Number of Ohio live births per year (13 years) 1955-1967. (From the Division of Vital Statistics, Ohio Department of Health.)

In Ohio, there were 185,204 live births reported during 1967. From this maternal mortality study, the Committee classified 52 maternal deaths for the year (Fig. 1). The maternal mortality rate was 0.28 per 1,000 live births, or 2.87 per 10,000 live births for 1967.

In addition, the Ohio Department of Health, Bureau of Vital Statistics, registered 2,528 "stillbirths" during 1967, to total 187,732 births recorded.

Discussion

The progressive annual decline in Ohio live births since 1957 has been noted for a decade (Fig. 2). However, the number of "stillbirths" has remained about constant, at least for the last three years reported.

During 1967 the Committee voted 52 of the 74 cases as *maternal* deaths. Forty-two (76 percent) were among white women; seven were "teenagers" while most (23) were in the 20-year age brackets. The great majority of deaths (43) occurred *in* hospitals; but *five* died at home, and *four* died enroute to hospitals.

A total of *12* patients *died undelivered;* there were nine Cesarean sections (all antemortem) and one laparotomy for an ectopic pregnancy, while *two* patients with ectopic gestation died "undelivered." Unlike the statistics of 1966,[2] 40 patients (88.4 percent) died postabortal or postpartum. There were 46 autopsies performed, 11 of them as coroner's cases.

The Committee voted 39 of the 52 cases (74.2 percent) as *preventable* maternal deaths, using "Guiding Principles"[8] as a guide. The majority of the cases were voted *personnel* responsibility.

Again the trend returns (from the 1966 statistics[2]) with *hemorrhage* leading in primary causes of death (12 cases), followed by *infection* (10 cases), and only two cases of *toxemia* (Fig. 1).

Pulmonary embolism (nine cases) predominates the 28 "Other Causes"; but there were *six* patients who died of amniotic fluid pulmonary embolism! All of the latter were proven by microscopic examination at autopsy.

Five patients died of hemorrhage precipitated by *ruptured uterus.* Not one defibrinated! There were *none* among the 1966 cases. Among the 52

patients there were 30 with High Risk features present before delivery; *five* had factors *related* to the cause of death!

Recommendations

• 1. Once again the Committee recommends The Ohio Maternal Mortality Study be continued with its research and educational facets. Only by an annual survey of statistics can trends in maternal mortality and morbidity be ascertained. Then education and information can be focused into the trends of prevailing problems.

• 2. Collateral *planning* by the Committee and members of the Ohio Department of Health should be followed by a progressive program to develop (a) an improved method to cull out maternal death cases now escaping inclusion in the study, and (b) a program to improve *perinatal* mortality statistics in Ohio. Although the Committee on Maternal Health has neither authority nor commitment to operate a perinatal mortality study, its members and The Council may lend important support to the initiation of "M&I Projects" in various communities throughout Ohio. The ODH is eager to participate!

• 3. All queries and projects assigned to the Committee by The Council having been completed, the Committee invites the submission of new problems or suggestions related to "Maternal Health in Ohio."

• 4. It is recommended that Committee and Council members remind program chairmen of medical societies that speakers from the Committee are available for local schedules; presentations on "Maternal Health in Ohio" are obtained by writing the Committee on Maternal Health, OSMA Headquarters, 17 South High Street, Columbus, Ohio 43215.

With genuine appreciation the Chairman acknowledges the devotion and support of Committee members who completed their duties effectively during the past year. For the Committee, the Chairman gratefully acknowledges the assistance extended by The Council, attending physicians, representatives of the many county medical societies, the Ohio Department of Health, Ohio Coroners Association, and numerous other agencies and individuals. Without their continued cooperation and efforts, this Maternal Mortality Study could not have been completed.

Respectfully submitted,
ANTHONY RUPPERSBERG, JR., M.D.
Chairman, Committee on
Maternal Health

Approved by The Council of the Ohio State Medical Association, September 20, 1970.

References

1. Maternal mortality study, statewide basis. *Ohio State Med J*, 51:886-888, 1955.
2. Committee on Maternal Health, OSMA: Maternal mortality report for Ohio-1966. *Ohio State Med J* 66:266-269, 1970.
3. Guiding principles for obstetric care. *Ohio State Med J* 53:1328-1329, 1957 (Revised 1963).

Attorney General's Opinion on Reporting Certain Emergencies

Following is the syllabus of Opinion No. 70-122, given by Attorney General Paul W. Brown on September 10, 1970.

1. A physician must report, pursuant to Section 2917.44, Revised Code, a wound caused by a deadly weapon even if the wound was the result of an attempted suicide.

2. A physician need not report, pursuant to Section 2917.44, Revised Code, an injury caused by the ingestion of barbiturates or drugs taken in an attempted suicide. However see also Section 313.12, Revised Code.*

3. The report, when filed with the proper law enforcement agency, pursuant to Section 2917.44, Revised Code, may be maintained as a confidential document of that agency.

(*Editor's Note: Section 313.12 pertains to notification by the physician in case of death by violence or suicide.)

Mental Health Program Concentrated in Stress Area

Thirteen communities in the central area of Cincinnati have formed the Central Community Health Board of Hamilton County to develop a comprehensive mental health program.

The areas are Avondale, Clifton, Clifton Heights-Fairview, Corryville, East End, Evanston, Mount Adams, Mount Auburn, North Avondale, Over-the-Rhine, Saint Bernard, Walnut Hills and the West End.

The new organization has an unusual twist: Residents will be asked to pinpoint neighborhood problems which create stress. The CCHB can then work on those situations in a long range manner to remove sources of mental illness, as well as to maintain a favorable environment for good mental health in a neighborhood.

The board had the cooperation of and a $40,000 grant from the Hamilton County Community Health and Mental Retardation Board to further develop its program.



Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

THE STOPPER



LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

first aid in diarrhea of acute gastroenteritis

PROMPT ANTIDIARRHEAL ACTION
Roentgenographic studies demonstrate that the motility-lowering activity of Lomotil is concentrated in the first three hours and continues for at least six hours.

Clinical investigators have found ample confirmation of these determinations. Lomotil has reduced diarrheal urgency in many patients within one hour.

OPTIMAL ANTIDIARRHEAL CONTROL
Numerous investigators have remarked on the high degree of effectiveness of Lomotil in a variety of diarrheal disorders. Lomotil has given good to excellent relief of symptoms in many patients who had failed to respond to other measures.

UNSURPASSED ANTIDIARRHEAL ACCEPTANCE
Patients prefer Lomotil for its convenience, its prompt control of diarrhea and its relief of cramping and urgency. Physicians specify Lomotil for its dependable action and its relative freedom from side effects when taken as directed.

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:
3-6 mo. .. ½ tsp.* t.i.d. (3 mg.)
6-12 mo. .. ½ tsp. q.i.d. (4 mg.)
1-2 yr. ... ½ tsp. 5 times daily (5 mg.)
2-5 yr. ... 1 tsp. t.i.d. (6 mg.)
5-8 yr. ... 1 tsp. q.i.d. (8 mg.)
8-12 yr. .. 1 tsp. 5 times daily (10 mg.)
Adults: ... 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.
*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

953

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in cardiac edema

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories



Professional Activities

Cincinnati Based "OMEN" Covers Large Area

Each Thursday at 12:00 noon an estimated 9500 physicians assemble in 67 hospitals in parts of Ohio, Kentucky, Indiana, and West Virginia to hear programs from the Ohio Medical Education Network (OMEN).

In the greater Cincinnati area WGUC-FM (90.9 MHz) broadcasts the OMEN discussions. In 1970-71 physicians in the WGUC-FM audience will hear discussions on the primary prevention of coronary heart disease, drug abuse, rheumatoid arthritis, and other topics of current interest.

WGUC-FM emanates from the campus of the University of Cincinnati. Its participation in OMEN provides an opportunity for area practicing physicians to update their knowledge of medicine during their lunch hours without taking time out for a formal meeting. Since the programs are on public airwaves, the doctors may also receive the broadcasts in their homes, offices or automobiles.

The Thursday noon OMEN broadcasts began October 15 and will continue through April 1, 1971. This is OMEN's ninth year of operation.

OMEN broadcasts are authorized for continuation study credit by the American Academy of General Practice. The programs are supported in part by educational grants from the Merck Sharp & Dohme Postgraduate Program and the American Cancer Society.

Two Named to Board of Ohio Medical Indemnity

Two Ohioans, Phillip W. Tefft, of Columbus, and Wendell D. Stewart, of Lima, have been elected to the Board of Directors of Ohio Medical Indemnity, Inc., the OSMA-sponsored Blue Shield plan in Ohio. They were elected by the Board to fill vacancies until its next annual meeting.

Mr. Tefft is president and chairman of the Board of the Claycraft Company, Columbus. He was born in Darlington, Pa., and graduated with a Bachelor of Ceramic Engineering Degree from Ohio State University. He also attended Alfred University, Alfred, New York, and is currently serving as chairman of the University's Board of Trustees.

He is also chairman of the Board of Basic Electric Company and ECOL, Inc., both in Columbus. In addition, he is treasurer of the Ohio Ceramic Industries Association and is director of the Structural Clay Products Institute and the Mid-East Structural Clay Products Institute.

Mr. Tefft is a member of the Executive and Steering Committees of the Development Committee for Greater Columbus. He is also chairman of the organization's Housing and Urban Renewal Committee.

Mr. Stewart is vice-president and treasurer of Superior Coach Corporation (a division of Sheller-Globe Corporation), Lima. He was born in Allen County and is assistant treasurer of the Sheller-Globe Corporation and a director of the Metropolitan Bank in Lima. He is also a member and former president of the Board of Trustees of the Lima Memorial Hospital and a director and past president of the Lima Area Chamber of Commerce.



Investment Prognosis

By Frank Van Holte, Columbus

NOTWITHSTANDING THE Middle-East problems, the Vietnam conflict, the UAW strike against General Motors or what the administration in Washington does economically, the stock market is in a bull trend now. I believe this to be a fact but it isn't only my view. This opinion is the obvious current judgment of most of the market experts, and I am merely acting in the capacity of a reporter. It appears that I can best serve the medical profession by cutting through the maze of market opinions and reporting the consensus.

All of us understand, of course, that this new bull market or trend, will not be without temporary pullbacks or declines which will offer splendid opportunities to add to your holdings or to get into the market. Because the market is just plain bullish over the long trend, I again recommend that you check your shopping list of growth oriented stocks—now's the time to buy.

Incidentally, I am sure you have observed with me that some of the market experts are masters of the gobbledegook. One writer, for example, recently wrote "The Federal Reserve Board acted with an economy of ammunition and, in addition to being exactly adequate, were nothing less than elegant." How about that! That reminds me of the phrases "systematized logistical projection" or "balanced reciprocal capability" whatever they mean. And they talk about the mysteries of medical terminology!

The campaign against smoking cigarettes received a substantial boost from the state legislators this past year. State governments are steadily increasing their reliance on cigarette taxes and in fact, every state now levies a cigarette tax, with Pennsylvania imposing the highest tax-per-pack of 18 cents. West Virginia's rate rose from 1 to 12 cents a pack. I am sure an $80 per year additional cost of cigarettes in West Virginia will cause the two-packs-per-day smokers to seriously think about breaking the habit.

Social Security benefits of about $1,000 per month are being projected as a strong possibility within the next 25 years if Social Security legislation now pending in Congress is enacted as written. Amendments to the basic Social Security Act approved by the Senate Finance Committee indicate that the federal benefits table will show a maximum insurance amount of $660 by 1993, so that the combined benefit for a worker and his spouse would be just under $1,000 per month. But inflation will reduce the buying power of these benefits. U.S. Chamber of Commerce economists estimate that the 1942 dollar, now worth 42 cents will be worth 18 cents in another 28 years if the present rate of inflation continues. If this inflation trend persists, new cars costing $3,000 today will cost $7,000 in 1998; $25,000 homes will be priced at $58,000; $4,000 college tuitions will rise to $9,400. Isn't it imperative that we make investments that will grow in value to counteract the inflation?

My stock of the month to be added to the list of previous recommendations is "Binks Manufacturing Co.," a relatively small company located in Chicago. This stock is listed only on the Midwest Stock Exchange. Binks manufactures spray equipment and systems for the application of paint and other coatings and finishes. Sales and earnings are up sharply in 1969 and 1970. The annual dividend of $1.00 represents a yield of about 7 percent on the current value of this stock. This is an excellent stock for growth minded investors, and it also provides a generous yield on your investment. I recommend it highly. An investment in Binks, I believe, offers a fair promise or opportunity to overcome the erosion of inflation.

This monthly feature is written for *The Journal* and is particularly slanted to the needs and interests of physicians. Comments of readers are invited. Mr. Van Holte is associated with the underwriting and brokerage firm of Sweney Cartwright & Company, Columbus.

Notice To All Members!

Your Memberships in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA* (with other AMA publications), will expire on December 31. Here's how to renew them:

Mail your dues immediately to the Secretary-Treasurer of Your County Medical Society.

OSMA dues are $50.00. AMA membership dues are $110.00. If you don't know the amount of your County Medical Society dues, check with your local Secretary-Treasurer. Ohio Medical Political Action Committee—American Medical Political Action Committee dues are $25. OMPAC-AMPAC dues are voluntary and not tax deductible.

Many members probably will want to send one check to cover local, state, national, and OMPAC-AMPAC dues. **Make Check Payable To Your County Medical Society.**

Your local Secretary-Treasurer will forward state and national dues for you and other members to the Columbus Office of the OSMA. That office will transmit AMA dues to Chicago.

Your local Secretary-Treasurer will forward your OMPAC-AMPAC dues to OMPAC Headquarters.

As a part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal* and copies of the *OSMAgram,* without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA, Today's Health, American Medical News,* and an AMA specialty journal of choice.

The member who becomes eligible for exemption from dues, and wishes to take advantage of exemption, should make his wishes known to the secretary-treasurer of his County Medical Society. After exemption has once been established, the member is automatically carried over from year to year, unless the status changes.

Annual Roundup on Federal, State, and Local Taxes for Physicians

FOR TAXPAYERS who report on a calendar year basis the time is approaching for a review of reports to be filed and taxes to be paid under several categories of federal, state, and local tax laws. The following article is presented to furnish at least basic information on tax structures, deadlines for filing, forms to be completed, and potential liability of taxpayers under the various classifications.

Only general data can be given in an article of this nature. For specific information on individual tax liability, the taxpayer is advised to consult authentic tax manuals, seek the advice of authorized tax experts, or call upon personnel of respective taxing agencies. A tax expert can point the way to many advantages under various tax laws as well as guide the taxpayer away from embarrasing or perhaps costly errors.

The following tax categories are discussed in this article under respective headings:

(1) Federal Income Tax, including payroll deductions.

(2) The Federal Social Security program, including liability of physicians as employees or as self-employed persons, withholdings from employees' wages, etc.

(3) Ohio Personal Property Tax.

(4) Ohio Workmen's Compensation Tax, required of those with three or more employees (optional for those with one or two) and the Disabled Workmen's Relief Fund Tax.

(5) Ohio Sales and Use Tax.

(6) Ohio and Federal Unemployment Insurance Taxes.

(7) Municipal Payroll Tax, applying to residents of cities or villages which have such tax.

Information in this article is confined to those taxes on which the taxpayer or employer must file periodic returns. It does not include reviews of such taxes as those on real property, for which the taxpayer is billed directly, nor does it include discussion of many excise taxes for which the vendor of goods or services is primarily responsible; neither does it include a discussion of licenses.

FEDERAL INCOME TAX

The Tax Reform act of 1969, signed into law by the President on December 30, 1969 and effective as of that date, make numerous changes in regard to the filing of forms and payment of taxes for 1970 and subsequent years. Many provisions of the Act are complicated, particularly in regard to retroactive dates, and taxpayers may wish to give attention to their records covering 1968 and 1969 as well as 1970.

Changes Effected by the Reform Act

The official printing of the Tax Reform Act of 1969 comprises some 250 pages of type. Yet these pages contain little more than revisions in the Federal tax structure, and complement previous revisions and documents going back as far as the Internal Revenue Code of 1954. It is obvious, therefore, that an article of this nature can only touch upon high points of the law and call attention to sections that are of general interest to most taxpayers.

Here are some of the major changes contained in the Reform Act.

- The Act increases the personal exemption from $600 to $625 for 1970 and to $650 for 1971. There are still higher personal exemptions the next two succeeding years.

- For 1970 the percentage standard deduction for individual taxpayers who do not itemize deductions remains the same—10 percent of adjusted income, with a maximum of $1,000. For 1971 the applicable deduction is increased to 13 percent, with a maximum of $1,500.

- The minimum standard deduction, on the other hand, is changed for both 1970 and 1971. The former minimum standard deduction—$200 plus $100 for each personal exemption up to $1,000—is increased to $1,100 and is now called a "low income allowance." This new provision will permit an increased level of untaxed income

for dependents, such as children, as well as for persons in the low income brackets.

• The surcharge on income tax liabilities is extended to June 30, 1970 at a rate of 5 percent. For taxpayers who pay on a calendar year basis, the surcharge is 2½ percent for the year.

• Income averaging rules have been substantially simplified and extended under the Act, and the definition of income subject to averaging has been expanded. Income averaging may be to the advantage of a taxpayer who receives a substantially greater than usual income during the year.

• Beginning for the taxable year 1971, a new tax rate scale is established for single individuals, giving them some tax relief. A similar scale also is established for "heads of households," adjusting their tax rate downward somewhat for 1971.

• The Act in general stiffens provisions dealing with charitable contributions. The general limit for individuals has been raised from 30 percent to 50 percent of adjusted gross income. Contributions to private foundations are still limited to 20 percent unless they are made directly to an operating foundation or distributed to an operating foundation or a public charity within two and a half months of the end of the tax year.

• The Act generally limits the allowable methods of depreciation or amortization of improved real estate.

• The Act tightens restrictions for nonfarmers where farm losses may be used to offset nonfarm income. Siinilar restrictions apply to dealings in livestock and other "hobbies."

• The Act repeals the 7 percent investment credit, with certain exceptions for construction projects begun on or after April 19, 1969.

• In regard to capital gains and losses, new rates are effective from January 1, 1970. For individuals, the 25 percent alternative tax continues to apply to the first $50,000 of long-term capital gains. Additional gains are included in ordinary income and taxed at progressive tax rates.

• On capital losses of individuals, beginning in 1970, only 50 percent of net long-term capital losses may be deducted from ordinary income, subject to $1,000 limitation ($500 for a married person filing separately). Carry-over provisions will help the taxpayer with losses in excess of $2,000. Long-term and short-term capital losses that arose prior to the effective date continue to be deductible in full, subject to the $1,000 limitation. Long-term losses can still be deducted in full against short-term gains.

• For corporations, procedures for reporting capital gains and losses are detailed and complicated and need the attention of a tax expert.

• Under maximum rate on earned income there is a provision in the Act designed to separate for tax purposes earned income from investment income. The maximum rate on earned income remains at 70 percent through 1970; drops to 60 percent for 1971, and to 50 percent for years after that. The tax bracket for the remainder of the individual's taxable income will depend on the amount of earned taxable income.

• Effective for 1970, the Act provides a "minimum tax" at a rate of 10 percent to the extent that the aggregate amount of "tax preference" exceeds the sum of $30,000 plus the Federal income tax for the year. The taxpayer who believes this provision applies in his case will need the help of a tax expert.

• The limit on deduction allowed for dividends from personal holding companies paid by the 15th day of the third month after year-end is raised to 20 percent (from the previous 10 percent).

• A number of changes are made in regard to affiliated corporations and other controlled groups.

• Modifications are made in regard to qualified penson plans for small business corporations —or Subchapter S Corporations—effective in 1971 and subsequent years. Physicians involved in such plans would do well to discuss the new provisions with their agents.

FEDERAL INCOME TAX FORMS AND PROCEDURES

Forms for filing reports and paying income taxes are substantially the same as for last year. The basic form is 1040. Separate schedules in addition to Form 1040 are provided for reporting business and professional income, capital transactions and other income.

Who Must File

Every individual having for the taxable year a gross income of $600 or more must file a federal income tax return, with the following exceptions:

An individual who is not married as defined in the law need not file if the income is less than $1,700 (or $2,300 if the individual is entitled to an extra exemption by virtue of age).

A person who is entitled to make a joint return need not file if the income is less than $2,300 (and this figure is increased by $600 for each additional exemption to which the taxpayer is entitled).

A self-employed person must file a return if his income from self-employment is $400 or more.

Any person having worked and received a W-2 form showing withholdings must file in order to claim a refund.

Income Tax Surcharge

As previously indicated, the surcharge on income tax liability was extended through June 30, 1970 at 5 percent. For taxpayers paying on a calendar year basis, the surcharge is 2½ percent for the year. No surcharge has been indicated for 1971.

Averaging Income

Certain taxpayers who have experienced substantial increases in income for the year may find it to their advantage to average earnings over a period of years. The Act simplifies the procedure for averaging and expands the definition of income that can be included in averaging.

Income-Splitting

With some exceptions, a physician will find it to his advantage to file a joint return with his wife, whether or not the spouse has income of her own. An unmarried person who qualifies as "head of a household" may claim about one-half of the tax benefit afforded a married couple on a joint return. The head of a household will find a new scale of rates effective for 1970, and subsequent years.

Exemptions and Allowances

The personal exemption has been increased to $625 for 1970 and to $650 for 1971. The exemption may be claimed by the taxpayer for himself and for each dependent of close relationship, or for certain other dependents living in his household.

To claim an exemption for a dependent, the taxpayer must have furnished over a half of the actual amount used for the dependent's support in the taxable year. Scholarships do not count as income to the child in determining the extent of parental support.

Exemption also is contingent upon the dependent, other than a child, having a net income of less than $600 for the year. A child may earn $600 or more and still qualify as a dependent if he is under 19 or a full-time student for five months during the year, or taking on-the-farm training, provided the taxpayer contributes more than half of his support.

An additional personal exemption of $625 may be claimed by the taxpayer if he is over 65, another if he is blind; another if his spouse is blind; and still another if the spouse has reached the age of 65. (These provisions do not apply to dependents other than spouse.)

Declaration of Estimated Tax

Virtually all physicians in private practice, and other persons who have income from sources other than wages subject to withholdings, are required to file declarations of estimated income tax, and to make periodic payments on estimated tax.

Regulations issued under authority of the Social Security Amendments of 1965 require self-employed persons to include their self-employment social security tax in their declaration of estimated tax.

Specifically, every citizen or resident of the U.S. is required to make a declaration if his total estimated tax exceeds his withholdings (if any) by $40 or more; and

(a) He can reasonably expect gross income exceeding—

(1) $10,000 for a head of a household or a widow or widower entitled to the special tax rates;

(2) $5,000 for other single individuals;

(3) $5,000 for a married individual not entitled to file a joint declaration;

(4) $5,000 for a married individual entitled to file a joint declaration, and the combined income of both husband and wife can reasonably be expected to exceed $10,000: or

(b) He can reasonably expect to receive more than $200 from sources other than wages subject to withholdings.

The final quarterly declaration for 1970 taxes is due January 15, 1971.

A single declaration may be made on form 1040-ES on or before April 15, 1971, for the 1971 taxable year, or, quarterly declarations may be made on or before April 15, June 15, September 15, 1971 and January 15, 1972.

The estimated tax may be paid in full with the declaration on or before April 15, or quarterly on the dates indicated above. The estimate must be within 80 percent of actual tax to avoid a penalty for most taxpayers. Amended declarations should be filed if the estimated income changes substantially.

Husband and wife may file separate declarations and a joint final return, or may file a joint declaration and separate final returns.

Adjusted Gross Income

For the person on salary, the total salary plus amounts received from interest, dividends, rent or from other sources constitutes the gross adjusted income.

The physician in private practice arrives at his adjusted gross income by adding to his cash receipts, interest, dividends, rent, etc., and deducting all items of expenditure necessary in earning his income. (In place of cash receipts, he may include total charges if he uses accrual method of reporting income.)

Following are the more important items that may be considered for deduction.

Deductible Business Expenses

Office Rent—Rent paid to another person for office space may be deducted, but no more than 12 months rent in one year. That portion of rent paid for the office in a combined office-home may be deducted on a pro-rata basis of space used. If the physician owns his own home-office combination, he may not deduct rent, but may claim depreciation on that portion used as an office, again on a pro-rata basis.

Automobile—Prorated cost of an automobile used for professional purposes may be deducted, the proportion of deduction based primarily on mileage. It is unlikely that a physician could claim, to the satisfaction of IRS, full deduction on an automobile even though he may maintain one car for professional purposes and another for family use. The matter of commuting from home to office comes into the picture, as does personal, social, and family use of the car. The cost of an automobile includes expenses for repair, upkeep, gasoline, service, etc.

Depreciation may be deducted on an automobile used in professional business. Annual depreciation may be deducted on the basis of cost, less salvage value, divided by the number of years the taxpayer uses the vehicle, and subject to any gain or loss on trade. The physician should seek the advice of a tax expert as to whether the "declining-balance method" of depreciation would be advantageous to him.

Damage to an automobile used in professional work, not done through negligence, and not covered by insurance, is a deductible item.

Under specified conditions the taxpayer may choose to deduct a flat allowance based on mileage accumulation. The allowance, if the taxpayer is eligible, is 12 cents per mile for the first 15,000 miles and 9 cents for additional miles of business travel.

Other Transportation Cost—Deductible items include sums paid for taxi fare and other transportation for professional purposes, salary of a chauffeur whose duties relate to professional calls, etc.

Professional Dues and Publications—Dues paid to professional associations to which the physician belongs, in the interest of his profession, are deductible. Publications purchased in the interest of his professional work become deductible items, as do publications purchased for the waiting room.

Refresher Courses—The Internal Revenue Service makes a distinction between expenses for advanced education and those for refresher courses (Section 1.162-5 of the IRS regulations).

Deductions may be made for "refresher" type courses, or those attended to maintain the skills of the physician and to keep him abreast of developments in his field of practice. Cost of education designed to prepare the practitioner to enter a specialty is not deductible.

Travel Expenses paid for professional or business purposes, such as attending medical meetings, are deductible. Emphasis is placed on the distinction between travel time and expenses devoted to business or professional purposes and that used for vacation or entertainment. Regulations are less restrictive for the taxpayers if the trip does not exceed a week or if personal or vacation time does not exceed 25 percent of the total time of the trip. Expenses for personal activities such as sightseeing, social visiting, personal entertaining, or other recreation, are not deductible. A physician who is accompanied by his wife to a medical convention may deduct the amount that the trip would have cost him alone.

Records should indicate a distinction between travel expenses, transportation expenses, and business entertainment expenses while traveling. Meals and lodging usually may not be deductible if the trip is no longer than a working day or the stay is not overnight.

A physician traveling abroad should be careful to distinguish between time and expenses involved in professional activities and those having to do primarily with travel.

Entertainment Expense—The taxpayer must show proof and degree of business relationship for the Federal income tax treatment of certain business travel, gift, and entertainment expenses.

In general, a physician may deduct on his Federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service by appropriate evidence that such expenses are ordinary and

necessary business expenses and clearly related to the production of business or professional income.

Exact records on each item are important. Here are criteria that may be used to determine the deductibility of entertainment expenses:

Specific purpose of entertainment; nature of the doctor's practice; period of time in practice; number of patients he already has; percentage of patients received as referrals; names of individuals entertained and reason why additional income could reasonably be expected from each; whether or not referrals were actually received from doctors entertained and any indication of the effect of the entertainment on these referrals; number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive; whether or not the other doctors in the same type of practice in the locality have entertainment expenses.

Depreciation—Important principles in regard to claiming depreciation are contained in Treasury Department Publication No. 456, entitled *Depreciation, Guidelines and Rules.*

Depreciation may be claimed on virtually all equipment and furnishings of more or less permanent value used in practice; also on buildings used for business or professional purposes.

If the taxpayer is unfamiliar with methods of claiming depreciation, he may wish to consult a tax expert as to which method would be to his advantage—straight line, declining balance, or sum-of-the-digits method.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Other Business Expenses—Salaries of all persons whose duties are connected with professional work, and the employer's share on Social Security and other payments made in behalf of employees; items consumed-in-the-using such as medicines, bandages, laboratory supplies, etc.; uniforms or other garments used in professional work but not suitable for street wear; cost of telephones, telegraph, heat, light, water, etc.; Ohio and Federal gasoline tax, if this has not been included in cost of gasoline; interest on business indebtedness; cost of replacement or repair of professional equipment lost or damaged by fire, theft, etc., not covered by insurance; certain legal expenses, etc.

Termination of Investment Credit

The 1969 Act repeals the 7 percent investment credit in the case of property acquired, or the construction of which is begun, on or after April 19, 1969, with certain exceptions in unusual situations.

Nonbusiness Deductions

Regardless of whether or not the taxpayer claims business expenses, he may claim the following deductions if eligible to do so, providing that there is not a duplication of deductions under the two categories.

Medical, Dental, and Drug Expenses—Deductible items under these headings include the cost of diagnosis, care, mitigation, treatment or prevention of disease or any treatment that affects a part or function of the body; also costs of transportation primarily for or essential to medical care and cost of travel prescribed for relief of specific ailments; costs of medical and hospital insurance; cost of drugs whether or not prescribed (but not toiletries and sundries); vitamins and supplements if prescribed. (Cost of special foods and beverages is not deductible as medical expense if taken as substitutes for normal food and drink.)

Maximum ceilings on medical deductions no longer apply.

Fifty percent of the premium paid for medical care policies, including Medicare Part B payments are deductible up to $150. The remaining balance is deductible as ordinary medical care expense.

The taxpayer may deduct under this category for himself, his wife, and his dependents expenses which exceed 3 percent of adjusted gross income, on condition that the amount of deductions for drugs is in excess of 1 percent of adjusted gross income.

Deductions may not be claimed for medical expenses reimbursed by insurance.

Contributions, Gifts, etc.—The 1969 Act makes substantial changes in this category.

In general, the Act increases the limitation on the charitable contribution deduction for individuals from 30 percent to 50 percent of adjusted gross income beginning in 1970. The increased deduction is not available for contributions to private foundations, unless the private foundation meets certain rules regarding distributions or is an operating foundation Moreover, the increased limitation is not available for contributions of appreciated long-term capital gains type property, unless the

(Continued on Page 1232)



The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can strike at the most inopportune time, it takes a comprehensive agent to treat the total diarrheal syndrome and help get the patient back on the job. That's why so many physicians rely on Donnagel, especially during the fall and winter months when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. It also contains the belladonna alkaloids to calm GI hypermotility and help relieve the distressing discomforts which so often accompany diarrhea. Certainly it's less expensive and more convenient than taking two medications. And the dosage is lower too. Available in the handy 4-oz. plastic bottle at pharmacies everywhere on your prescription or recommendation.



When diarrhea and its discomforts separate a man from his job . . .

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Each fluid ounce contains: Kaolin, 6 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Sodium benzoate (preservative), 60 mg.; Alcohol, 3.8%.

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Coughs are back.



clear the tract with the

Robitussin® Line

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For coughs of colds and "flu"

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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Alcohol, 3.5%	

For unproductive allergic coughs

Robitussin A-C®

Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.
(warning: may be habit forming)	
Alcohol, 3.5%	

Non-narcotic for 6-8 hr. cough control

Robitussin-DM®

Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Dextromethorphan hydrobromide	15.0 mg.
Alcohol, 1.4%	

Clears sinuses and nasal stuffiness as it relieves cough

Robitussin-PE®

Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Phenylephrine hydrochloride	10.0 mg.
Alcohol, 1.4%	

Robitussin-DM in solid form for "coughs on the go"

Cough Calmers™

Each Cough Calmer contains:

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Dextromethorphan hydrobromide	7.5 mg.

Select the Robitussin® "Clear-Tract" Formulation That Treats Your Patient's Individual Coughing Needs:

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All 5 Robitussins have an EXPECTORANT-DEMULCENT action. Keep this handy chart as a guide in selecting the formula that provides the *extra* benefits you want for your patient.

	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN®					●
ROBITUSSIN A-C®	●	●			
ROBITUSSIN-DM®	●		●		●
ROBITUSSIN-PE®				●	●
COUGH CALMERS™	AHR		AHR		AHR

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taxpayer is required to take such appreciation into account for tax purposes or elects to do so. The appreciation is taken into account by reducing the amount of the contribution by half of the potential long-term capital gain.

The taxpayer who has made provision for gifts in his will may wish to review these provisions in light of the Tax Reform Act of 1969. This same precaution would apply where trusts are involved.

Interest—The taxpayer may deduct interest on a personal note to a bank or individual, a mortgage on his home, a life insurance loan if the interest is paid in cash, or interest on delinquent taxes.

Taxes—Deduction may be made for taxes paid on personal property or real estate, for city income taxes, retail sales taxes, and state gasoline taxes.

The following state and local taxes may not be deducted: Auto plate and driver license fees (personal cars), cigarette and tobacco taxes, alcoholic beverage taxes, admission, occupancy, and transfer taxes.

Casualty Losses and Thefts—The taxpayer may deduct losses due to destruction of property by fire, stolen property or cash, and storm damage, provided the amount is in excess of $100 for each loss and provided the amount is not claimed as a business deduction and not covered by insurance.

Retirement Income

Pensions and annuity payments received by individuals fall into three classes for federal income tax purposes: Nontaxable, fully taxable, or partly taxable. Certain items of retirement income also may be subject to credit, allowances varying according to whether the retired person is under age 65, over that age, or over age 72. A person who is receiving retirement income, therefore, would do well to check with an office of the Internal Revenue Service, or consult a tax expert. The retirement income credit may be deducted before figuring the surcharge.

Standard Deduction

The Tax Reform Act makes important changes in regard to the percentage standard deduction and the former minimum standard deduction (now the low income allowance), and permits the taxpayer to deduct as "Standard Deduction" the larger of the two.

The percentage standard deduction (claimed in lieu of listing nonbusiness deductible items) for 1970 remains the same as it has been—10 percent of adjusted gross income, with a maximum of $1,000. For 1971 it is increased to 13 percent with a maximum of $1,500; for 1972, to 14 percent with a maximum of $2,000; and for 1973 and thereafter, to 15 percent with a maximum of $2,000.

The minimum standard deduction is now called a "low income allowance" and is $1,100 for 1970 and subsequent years. A special scale applies to a married individual filing a separate return.

Other Provisions

Dividends paid out of a corporation's current or accumulated earnings are taxable. The first $100 of such dividends are tax-free when the taxpayer takes the dividend exclusion. On a joint return the exclusion may be up to $200.

An individual who is 65 or older may exclude from gross income, any capital gain attributable to the first $20,000 of the **sales price** of his personal residence, provided the property has been owned and used by him as his principal residence for at least 5 years during the 8-year period preceding the sale.

The taxpayer who, because of employment, must engage a sitter for a child up to age 13, or for a physically or mentally defective dependent, may qualify for deduction on expenses for this purpose.

Partnerships

The partnership itself is not subject to income tax, but is required to file an information return, Form 1065. Tax liability falls upon the individual partners. Simple agreements for the sharing of expenses, co-ownership and maintenance of property, and the like, are not considered partnerships, unless a profit element also is involved.

Where an actual partnership exists, partners would do well to seek expert advice in regard to tax liability. An Opinion of the Ohio Attorney General given in 1961 permits professional men to associate as parnerships under Ohio limited partnership law and thus make themselves eligible for favorable tax action under the U.S. Internal Revenue Act.

Professional Corporations

Physicians are permitted to incorporate under Ohio law, and to claim certain tax benefits as corporations. This is a field for the tax expert. Physicians who are contemplating incorporating obviously will want expert advice as to the ad-

vantages and possible disadvantages of such action taxwise as well as from every other standpoint.

Retirement Programs for Self-Employed

The Tax Reform Act of 1969 makes certain changes in regard to retirement programs established under the Self-Employed Individuals Tax Retirement Act, better known as the Keogh Act, effective for 1971. Physicians undoubtedly will want to review their retirement programs with expert advice in view of revisions in the law.

District Office and Districts

Income tax payments and returns must be made at or mailed to the office of the District Director of Internal Revenue for the district in which the taxpayer has his legal residence. There are two districts in Ohio. Counties comprising each district follow:

For the Cincinnati District—Director of Internal Revenue, Cincinnati, Ohio 45298, comprising the following counties: Adams, Athens, Brown, Butler, Clark, Clermont, Coshocton, Clinton, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Hamilton, Highland, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Miami, Montgomery, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Preble, Ross, Scioto, Union, Vinton, Warren, and Washington.

For the Cleveland District—Director of Internal Revenue, Cleveland, Ohio 44113; comprising the following counties: Allen, Ashland, Ashtabula, Auglaize, Belmont, Carroll, Champaign, Columbiana, Crawford, Cuyahoga, Darke, Defiance, Erie, Fulton, Geauga, Hancock, Hardin, Harrison, Henry, Holmes, Huron, Jefferson, Lake, Logan, Lorain, Lucas, Mahoning, Medina, Mercer, Monroe, Ottawa, Paulding, Portage, Putnam, Richland, Sandusky, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne, Williams, Wood, and Wyandot.

Claims for refunds are mailed to the District Director of Internal Revenue, Cincinnati, Ohio 45298.

FEDERAL TAX WITHHOLDINGS

The Tax Reform Act of 1969 made a number of changes in regard to withholdings from employees' wages. Employers will find *Circular E*—Employer's Tax Guide (Revised June, 1970) invaluable as a guide to changes as well as to procedures for withholding taxes. The new guide became effective as of July 1, 1970. A previous set of tables applied to withholdings before that date.

Here are some of the changes that should be noted.

- An employee who anticipates no tax liability for the year, may sign Form W-4E and be exempt from withholdings for federal tax purposes.

- Farm workers and household employees (previously exempt from withholdings) may now elect to have withholdings for income tax purposes.

- Alternative methods for payroll withholdings are provided. Withholdings may be made by referring to the tables in *Circular E—Employer's Tax Guide,* or use a percentage method. *Publication 493* (alternative formula tables for percentage withholdings) is available from IRS offices.

- The rules for claiming additional allowances on account of large itemized deductions have been liberalized.

- Beginning January 1, 1971, a new rule in regard to voluntary withholdings from pensions and annuities becomes effective.

To review the Federal law in regard to payroll withholdings, every employer of one or more employees, where an employer-employee relationship exists, must withhold from the employee's wages an amount prescribed and turn over these withholdings to the Federal government periodically. The procedure for withholdings is described in detail in *Circular E—The Employer's Tax Guide.*

Withholding rules apply to Social Security taxes and FUTA (Federal unemployment) taxes. See additional information under Social Security and Unemployment Taxes.

SOCIAL SECURITY TAXES

No change is made in the Social Security tax rates by the Tax Reform Act of 1969. The tax rates for 1970 are the same as those for 1969, but another step in the escalating rates becomes effective on January 1, 1971.

For 1970 the deduction is 4.8 percent (4.2 percent for old-age, survivors, and disability insurance, plus 0.6 percent for hospital insurance benefits) on the first $7,800, each on employees and employers, or a total of 9.6 percent.

Beginning January 1, 1971, Social Security deductions will be 5.2 percent each for employee and employer on the first $7,800, or a total of 10.4 percent.

For 1970, the self-employed person deducts 6.9 percent on the first $7,800. This amount is

paid quarterly with the Declaration of Estimated Tax (Form 1040ES).

Beginning January 1, 1971, the self-employed tax is 7.5 percent on the first $7,800 of income.

The physician who has a part-time salaried position through which social security taxes are withheld need not pay the self-employed tax if social security taxes are withheld on income up to $7,800. If the salary subject to withholdings is less than $7,800, he must pay self-employment tax on the difference between the maximum and his salary.

Federal Health Insurance Programs

The Medicare program is in two parts: (1) hospital insurance, and (2) medical insurance.

Persons who are approximately age 65 and wish to take advantage of the hospital insurance program should notify the Social Security office at least a month before reaching age 65. Retirement is not a factor in eligibility for either the hospital insurance or the medical insurance programs.

Persons aged 65 and over are eligible for benefits under the medical program provided that they enroll during a specified enrollment period and agree to pay a monthly premium into the medical program fund. The monthly premium was $4 for the early part of 1970 and was increased to $5.30 effective June 1, 1970.

Benefits under the medical program are for the individual enrollee only. The spouse who is aged 65 must enroll also if benefits are desired for both husband and wife.

UNEMPLOYMENT TAX

Physicians and other employers should note major changes in this category effective for 1972 and subsequent years, as well as minor changes effective for 1970 and 1971.

The Federal Employment Security Amendments of 1970 (Public Law 91-373), approved August 10, 1970, serve to extend the Federal-State unemployment compensation program. There is every indication, based on the tenor of the coming Ohio General Assembly, that the Ohio unemployment compensation law will be amended to coordinate it with the new Federal law. Procedures for filing forms and paying unemployment taxes for 1970 and 1971 are covered in the current Ohio law, with the exception of one-tenth of one percent increase in the federal tax.

The Federal Employment Security Amendments of 1970 increased the Federal Unemployment tax rate from 3.1 percent to 3.2 percent, retroactive to January 1, 1970.

Under the new law, employers liable for the Federal unemployment tax (those with four or more employees) must use a rate of 0.5 percent of their taxable payroll in computing Federal unemployment tax beginning with the third quarter of 1970. (The previous rate was 0.4 percent.)

The new law does not require adjustment to deposits for the first two quarters of 1970, and no penalty for underdepositing for the first two quarters will be imposed on the additional tax resulting from the rate increase. However, any additional tax due at the end of the year must be deposited or paid on or before the date the form 940 is filed.

Also, beginning in 1970, the new law excludes from Federal unemployment tax the amount paid for the services of:

1) Spouses of students employed by a school, college or university under a program of assistance to the student.

2) Students less than 22 years of age employed under specified work-study programs.

3) Individuals employed in hospitals in which they are also patients.

Effective in 1972

The following changes in the Federal law are effective **beginning January 1, 1972:**

1) The limitation on taxable wages for each employee is increased from $3,000 to $4,200.

2) The definition of an employer is changed. A person is an employer for the current calendar year if—

a) during any calendar quarter of the current or preceding calendar year he paid wages totaling $1,500 or more, or b) he had, during the current or preceding calendar year, **one** or more employees at any time in each of 20 calendar weeks.

(For 1970 and 1971 he is an employer if he had **four** or more employees during any day in each of 20 calendar weeks in the current or preceding year.)

3) The definition of "agricultural labor," which is exempt from the Federal unemployment tax, is changed.

Ohio Unemployment Tax

Ohio and Federal unemployment tax laws are coordinated, so that the Ohio tax offsets much of the Federal tax. If a taxpayer has paid his Ohio tax in full, the Federal tax is reduced to a minimum.

In general, employment of **three or more persons** renders the employer liable for this tax.

Excluded from the number of employees is a minor who does short-time work but whose principal occupation is that of student, and a person doing casual labor not in the course of the employer's regular business or profession. Careful consideration should be given to an extra worker as to whether he should be included as an employee or as an independent contractor. A physician who is in doubt as to his liability should request clarification from the Ohio Bureau of Employment Services, 145 South Front St., Columbus, Ohio 43216.

Reports are made during the month following each calendar quarter on forms supplied by the Bureau. The tax is established for each employer annually. A copy of the calculations made by the Bureau is mailed before the first of the year to each employer. This form also shows how the rate was calculated.

For 1970 and 1971 only the first $3,000 paid by any employer to any one individual "in employment" within a calendar year is taxable.

Penalties are specified in the Ohio Code for failure to comply with provisions of the law.

Liable employers should furnish a form BUC-400 to each employee upon separation.

Future Planning

As indicated in the foregoing summary, all employers of one or more employees will become subject to the Federal unemployment tax in 1972 and will be taxed on the first $4,200 of each employee's annual wages. There is little doubt that the same conditions will be written into the Ohio law to become effective in 1972.

There are certain carry-over provisions in the law that perhaps will work to the advantage of employers now covered. A physician who is not presently covered by reason of having a limited number of employees may wish to consider voluntary coverage at this time. A tax expert can advise on this point, or the physician-employer may contact the Ohio Bureau of Employment Services, 145 South Front Street, Columbus 43215 for advice.

OHIO SALES AND USE TAX

Section 5739.02 Revised Code levies an excise on each retail sale made in Ohio of tangible personal property.

"In Section 5739.01, under the definition "vendor," the Revised Code states: "Physicians, dentists, hospitals, and veterinarians who are engaged in selling tangible personal property as received from others, such as eye glasses, mouth washes, dentifrices, or similar articles, are vendors.

Under the definition of "consumer," the Code states: "Physicians, dentists, hospitals, and blood banks operated by nonprofit institutions and persons licensed to practice veterinary medicine, surgery, and dentistry are consumers of all tangible personal property purchased by them in connection with the practice of medicine, dentistry, the rendition of hospital or blood bank service or the practice of veterinary medicine, surgery, and dentistry."

The Ohio Use Tax Law, passed in 1936, supplements the Retail Sales Tax Law and imposes a tax on the same basis as the sales tax on purchases made outside the State. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax, and paying it directly to the Department.

However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Ohio Department of Taxation, he is required to report such purchases to the Treasurer of State and pay the tax. Returns must be filed with the Treasurer by April 15 for purchases, during the period January 1 to March 31, and quarterly thereafter. The report is filed on Ohio Use Tax Form 1014. "The Quarterly Consumers Return."

The Sales and Use Tax is a bracket tax with a minimum rate of 4 percent in those counties which have not acted under the permissive tax authority. The permissive tax, authorized under Sec. 5739.021 of the Revised Code, may be levied by a county as an additional one-half of one percent. As of November, 1970, the additional tax was in effect in five counties—Allen, Cuyahoga, Hamilton, Lake, and Miami. The rate in these counties is 4½ percent, the total amount being reported and paid to the state.

Forms are routinely sent to physicians on record who have been assigned a Consumer's Use Tax account number. Physicians who have not been assigned an account number should write to the Ohio Department of Taxation in Columbus.

OHIO PERSONAL PROPERTY TAX

Returns under the Ohio Personal Property Tax Law must be made between February 15 and April 30 annually. One-half of the amount of the tax is paid when the return is filed, and the other half is due September 20.

For individuals and partnerships, Forms 910 and 911 are filed between February 15 and April 30 with the County Auditor of each county where personal property is held.

For corporations, Forms 930 and 931 are filed with the County Auditor between February 15 and April 30 if personal property is held in only one

county. Forms 945 and 931 are filed with the Ohio Department of Taxation if personal property is held in more than one county, also due between February 15 and April 30. Separate bills will be received from the County Treasurer for tangible personal property and from the Treasurer of the State for intangible personal property.

Certain changes have been written into the law in regard to some assessment valuation and rates, but these changes will be reflected in the new tax forms distributed for the current tax period. Rather extensive changes have been made in regard to farms and farm property. Personal property used in agriculture will be fully exempt from personal property taxation in 1973. The return forms reflect a reducing percentage of taxability in the interim years.

It must be kept in mind that tangibles to be listed include personal property used in business, such as a physician's office furniture, fixtures, equipment, supplies (including medicines), etc. Such tangible property should be listed at its true value. Counting the year of purchase as a half year, a depreciation of 10 percent annually from cost will be allowed until such equipment reaches a value of 30 percent. It should stop at that figure for a year. Then such office equipment may be reduced 2½ percent each year until it reaches a minimum value of 20 percent, which value should be kept as a utility value.

It should also be noted that personal investments such as corporation stocks, notes or mortgages, etc., are also taxable and must be returned in the personal property tax report along with business property.

When a physician engages in practice (or a person engages in business), in this state on or after the first day of January, he shall list all his taxable property, except inventory, as to value, ownership and taxing districts as of the date he engages in business. In listing inventory as to ownership and taxing districts he shall list the probable average value intended to be used in business from the date he engages in business until the first day of January next thereafter. The valuation of all property, including average inventory, to be returned for taxation shall be determined by multiplying the value of such property by a fraction whose numerator is the number of full months engaged in business during the year, and whose denominator is twelve, unless he shows the assessor, under oath, and by producing a copy of the return or assessment, that the same property has been listed or assessed for taxation for the year in this state.

Forms 937 and 902, obtained from the County Auditor, must be filed with the Personal Property Tax return to obtain a lesser value than book value.

Returns should be filed in duplicate. The so-called tangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

Accounts receivable are to be listed in accordance with Section 5711.18 of the Revised Code part of which reads, "Claim for any deduction from net book value of accounts receivable or depreciated book value of personal property must be made in writing by the taxpayer at the time of making return," on supplementary tax form 902.

To arrive at a fair estimate of his current accounts receivable, the physician is advised to note after each account what he considers its value. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise it should be listed at a percentage of its true value, or "no value" if that is the case. The total of these estimates is the amount to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts. It also allows him to depreciate the actual value of accounts returned in the tax year, but which have decreased in actual value during that year.

All taxable personal property and credits used in business shall be listed as of the close of business of the last day of December, annually, or the last day of the fiscal year.

As defined in Section 5701.07 R.C. credits mean "the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments."

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced."

It should be understood that there is no discrimination in the foregoing provisions against physicians. Every person who possesses intangible assets, such as accounts receivable, or any business or professional man who does business on a credit basis, must return his accounts receivable for taxation.

OHIO WORKMEN'S COMPENSATION

The purpose of the Bureau of Workmen's Compensation is to maintain a Workmen's Compensation Insurance Fund from which to pay medical expenses and compensation to workmen

for injury or occupational disease and to pay compensation to the dependents for death occasioned in the course of or arising out of employment.

Every employer in the State employing three or more persons regularly in the same business is required to furnish the Bureau of Workmen's Compensation with specified information about employees he has had during the previous year and to contribute to the State Insurance Fund in an amount based on the payroll and at a premium rate based on the class of risk. (The employer under certain circumstances may elect, under bond, to comply with the provisions of the law, secure authority to pay compensation, etc. direct.)

Employers of less than three employees may voluntarily subscribe to and obtain insurance in the Fund.

Insurance accounts are adjusted and reports made for the first half and second half of the calendar year. Reports are due with premiums attached within one month from the date on which the six months' period last expired. Another requirement is an advance permanent deposit, based on eight months' estimated payroll for the periods January 1-August 31, and July 1-February 28, respectively.

The Bureau of Workmen's Compensation comprises 16 regional offices in addition to the central office in Columbus, Ohio.

Disabled Workmen's Relief Fund

Effective in 1959, the Ohio General Assembly increased permanent and total disability benefits and enacted Senate Bill No. 472 to finance this increase by levy of an excise tax on employers of 3 cents per $100.00 of total aggregate gross payroll. This excise tax applies to employers of three or more employees and to employers of less than three persons who have voluntarily subscribed to Workmen's Compensation Insurance Fund; also self-insured employers. The tax is due and collected along with and a part of the semi-annual report to the Workmen's Compensation Insurance Fund.

CITY PAYROLL TAXES

Many municipalities in Ohio have enacted laws imposing income taxes on wage earners and placing the primary responsibility on the employer to make payroll deductions, file forms, and pay taxes to the city government. This responsibility falls upon a self-employed person, such as a physician in private practice.

Laws vary as to liability of a person who earns the major part of his income in one community and resides in another. The physician who moves into a new location would do well to inquire as to local tax laws.

OSMA Group Term Insurance Saves Money for Professional Corporations

The financial significance of professional corporations is becoming a matter of growing importance to doctors. Financial relief can now be achieved through the Ohio State Medical Association Group Term Life Insurance Plan.

OSMA Group Term Insurance is a tax-deductible employee benefit. The Master Group Term contract has been amended to meet all IRS requirements.

Premiums may be paid and deducted by the corporation. The employee is not taxed for the premiums paid by the corporation, and each employee may name his own beneficiary.

The only requirement is that all eligible employees must be covered. Coverage can be by a schedule relating to salary or by using the following scale:

Annual Salary less than $10,000—$5,000 life insurance;

Annual Salary $10,000 but less than $20,000—$12,500 life insurance;

Annual Salary $20,000 but less than $30,000—$30,000 life insurance;

Annual Salary $30,000 and over—$50,000 life insurance.

Other changes in the OSMA Group Term policy are:

1. Rates were reduced for all members under age 60.
2. Low cost dependent coverage was made available as an option.
3. Dividend option was changed to reduce premium instead of buying additional paid-up insurance as in the past.

Additional information about the Association's sponsored life insurance may be had by contacting the administrators of the plan — Turner & Shepard, Inc., 17 South High Street, Columbus, Ohio 43215.



Exhibits Wanted

1971 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association is just the place to display it. We are now accepting applications for the 1971 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus. EXHIBIT DAYS will be May 11, 12 and 13.

Mail application to the Ohio State Medical Association, 17 South High Street, Suite 500, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1971 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, Ohio, May 10-14

1. Title of Exhibit: _____
2. Name(s) of Exhibitor(s): _____

   Institution (if desired): _____

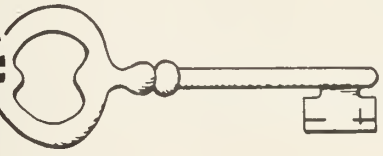
   City _____
3. Do you have a built-in exhibit? _____
4. Booth Requirements: Back wall _____ All sidewalls are 6′ deep
   (indicate footage)
5. Description of Exhibit: (Attach 200 word description to this blank)

Deadline For Filing Applications, February 1, 1971

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COLUMBUS, OHIO **MAY 10-14**

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Twins	$20.00 - $25.00

SOUTHERN HOTEL
South High and East Main Streets

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300 East Boad Street
(Woman's Auxiliary Headquarters)

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Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 10-14 (or for period indicated).

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Price Range_____

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Serum Hepatitis: Is the Physician Liable?

By James E. Pohlman, LL.B.

BLOOD TRANSFUSIONS have become commonplace in today's medical practice. As the use of blood transfusions has increased in the physician's practice in recent years, so has the nature and extent of the allied personnel and organizations needed to serve physicians in performing the procedure: medical technicians, processors, distributors, laboratories, and blood banks (both for profit and not for profit).

The use of blood transfusions, while bearing a high *benefit* component in favor of the patient, is not without *risk*. It is estimated that the incidence of serum hepatitis following blood transfusions is between 0.4 percent and 2 percent.

The patient who contracts serum hepatitis following a blood transfusion procedure is, moreover, a likely plaintiff in a personal injury action brought against one or more defendants: the attending physician, the hospital, the blood bank, the laboratory, or the processor. Usually the patient's attorney casts his claim against the defendant or defendants within the framework of a products liability action and attempts to prove that his claim is analogous to those involving adulterated products distributed and available for human use and consumption such as food and drugs.

Although the plaintiff's attorney generally has at least three specific theories upon which he may proceed [(1) negligence, (2) contract and (3) implied warranty, or "strict liability" as it is sometimes called], [1] he has usually tried to apply the theory easiest for him to prove—implied warranty or strict liability. By successfully invoking that theory of recovery the plaintiff could make a *prima facie* case (and thus have his case decided by the jury) merely by proving that he had a blood transfusion and that thereafter he developed serum hepatitis, i.e., he was entitled to have the jury draw the inference that the blood used in the procedure was adulterated with serum hepatitis at the time of the transfusion. The burden was then shifted to the defendant to explain why he (if the defendant were the attending physician) should not be held at fault. This was, as a practical matter, an insurmountable burden because of the medical fact that there is no known, reliable test for determining the presence of serum hepatitis in blood.

Until recently, the plaintiffs and their attorneys have met with little success when proceeding under this theory. The leading case, involving a hospital and decided in New York in 1954,[2] held that the transfusion of blood was a "service" incidental to the overall hospital treatment rendered to the patient rather than a "sale" and that, therefore, the traditional warranties recognized in commercial transactions were not applicable to blood transfusion procedures.

A case decided by the Illinois Supreme Court in September, 1970,[3] however, repudiated the rationale of the earlier New York case and held that a patient contracting serum hepatitis could successfully sue a hospital on the theory of strict liability. The case has aroused considerable comment, ranging from the unrestrained joy expressed by a national association of plaintiffs' lawyers ("Is it not arbitrary and indeed atrocious to exclude from the beneficence of the strict liability rule the unlucky person who happens to receive hepatitis virus in whole blood?")[4] to the dire predictions expressed by others that malpractice liability insurance premiums will be drastically increased and that physicians will now be faced with a Hobson's choice ["give (the) transfusion and risk (a) damage action for hepatitis infection or withhold the transfusion and risk (a) suit for malpractice"].[5]

What the effect of the Illinois decision will be elsewhere is difficult to judge: it is not likely, however, to have any impact in Ohio. The basis for this opinion is that during the last legislative session the Ohio General Assembly enacted Am. H.B.

Submitted November 6, 1970

Mr. Pohlman is a Columbus practicing attorney and is legislative counsel for the Ohio State Medical Association.

439, an act which in effect limits the liability of persons engaged in blood transfusion procedures (including, of course, physicians) to acts of negligence and bars the patient from bringing a suit for damages on a theory of implied warranty or strict liability.

By enacting Am. H.B. 439 the Ohio General Assembly has joined the state legislatures in 25 other jurisdictions that have adopted similar legislation in recent years.[6] Recognizing that those persons involved in blood transfusion procedures were entitled to legislative protection from liability except for acts of negligence, H.B. 439 was sponsored by the Ohio State Medical Association and introduced in the House of Representatives by Rep. Norman A. Murdock (R., Cincinnati). Mr. Murdock managed the bill ably in the House where minor amendments were made. Sen. Howard C. Cook (R., Toledo) became a cosponsor of the measure when it reached the Senate and very capably guided it through the Senate. Governor James A. Rhodes signed the bill on August 15, 1969 and it became effective on November 14, 1969.

As a result of the enactment of Am. H.B. 439,[7] the physician practicing in Ohio is now liable to the patient who develops serum hepatitis only if he has been guilty of some act or omission of negligence: he may *not* be held liable, contrary to his colleagues in Illinois, under a theory of strict liability simply because the patient unfortunately contracts serum hepatitis after a blood transfusion.

The Ohio General Assembly is to be commended for promptly adopting a fair and forward-looking solution to a difficult medical-legal problem.

References

1. See, for example, the discussion by the Ohio Supreme Court in *Lonzrick* v *Republic Steel Corp.*, 6 Ohio St. 2d 227, 218 N.E. 2d 185 (1966).
2. *Permutter* v *Beth David Hospital*, 308 N. Y. 100, 123 N. E. 2d 792 (1954).
3. *Cunningham* v *MacNeal Memorial Hospital*, ... Ill. ....., ...N. E. 2d .....(1970).
4. 12 *American Trial Lawyers Association News Letter*, No. 6.
5. 2 *Medical News Report*, No. 41.
6. *Cunningham* v *MacNeal Memorial Hospital*, supra.
7. Now Sec. 2108.11, Ohio Revised Code.

27th Annual

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December

New Antibiotics — Gentamycin, Carbentocillin and Others (Pharmacology Series) — Youngstown Hospital Association: December 14; Dr. G. A. Butcher and Dr. J. Conti.

January

Fifty Years of Surgical Progress—Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; January 13-14.

Recognition, Evaluation, and Control of Occupational Hazards — Training Institute, Environmental Control Administration, 1014 Broadway, Cincinnati 45202; January 18-22.

Orthopaedic Challenges — Reconstructive and Post-Traumatic — Cleveland Clinic Educational Foundation, January 20-21.

Selected Aspects of General Medicine — Sponsored by the University of Cincinnati College of Medicine and CONMED, Eden Avenue, January 20-21.

New Endoscopic and Camera Techniques (Gastroenterology Series) — Youngstown Hospital Association, January 25.

Tests of Pulmonary Gas Transfer—Clinical Problems of O_2 - CO_2 Exchange — Trumbull Memorial Hospital, Warren, luncheon program, January 26; Edward H. Chester, M.D., head, Pulmonary Section A, Veterans Administration Hospital, Cleveland, and assistant professor of medicine, Case Western Reserve University.

New Developments in Special Procedures, Complications and Legal Implications — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; January 27-28.

February

General Practice — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, February 3-4.

Hospital Infection Control — Sponsored by the University of Cincinnati College of Medicine and CONMED at the Shriners Burns Institute Auditorium and Cincinnati General Hospital, February 4.

Publication deadlines require that notices of postgraduate courses, in order to be published in these columns, must be received in *The Journal* office at least 60 days before the course is scheduled to be given.

Hepatitis: Subacute Hepatitis, Chronic Active Hepatitis (Gastroenterology Series) — Youngstown Hospital Association, February 8.

Disorders of the Red Cell — Cleveland Clinic Educational Foundation, February 10-11.

Facial Fractures — Repair and Plastic Surgery — Sponsored by the University of Cincinnati College of Medicine and CONMED at the Shriners Burns Institute Auditorium and Cincinnati General Hospital, February 15-19.

Granulomatous and Nongranulomatous Colitis (Gastroenterology Series) — Youngstown Hospital Association, February 22.

Physiologic Bases of Assisted Ventilation — Applied Respiratory Mechanisms — Trumbull Memorial Hospital, Warren; luncheon program. February 23; John J. Picken, M.D., instructor in medicine, Case Western Reserve University.

Electromyography — Ohio State University College of Medicine, at the Center for Tomorrow, 2400 Olentangy River Road. Columbus, February 23-25.

Review of the Connective Tissue Diseases by Systems. Manifestations and Management — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; February 24-25.

March

Ophthalmology Conference — Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus; March 1-2.

Selected Basic Science Applications to the Modern Clinical Laboratory — At Christ Hospital, Cincinnati; March 4; sponsored by CONMED and the University of Cincinnati College of Medicine.

Lederle Symposium — Cosponsored by the Ohio Academy of General Practice, at the Sheraton-Columbus Motor Hotel, downtown Columbus, March 7.

Drug-Induced Thrombocytopenia and Hemolytic Anemia (Hematologic Series) — Youngstown Hospital Association, March 8.

Pediatric Clinic Day — At Children's Hospital, 561 S. 17th Avenue, Columbus; sponsored by the Ohio State University College of Medicine; March 10.

Advances in Urology — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; March 10-11.

Lederle Symposium — Cosponsored by Ohio State University College of Medicine, at the Sheraton-Columbus Motor Hotel in downtown Columbus, March 14.

Internal Medicine — Sponsored by Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, March 17.

Shriners Burns Institute Symposium on Thermal Injuries — at the Shriners Burns Institute, March 18-19; sponsored by CONMED and the University of Cincinnati College of Medicine.

The Pathogenesis and Surgical Treatment of Duodenal Ulcer, lecture at Mount Sinai Hospital of Cleveland, 11:00 a.m. on Friday, March 19, by Lester R. Dragstedt, M.D., professor and chairman, Department of Surgery, University of Florida. Also **The Pathogenesis and Surgical Treatment of Gastric Ulcer,** lecture at 8:30 a.m. on Saturday, March 20. Contact Charles Marks, M.D., at the hospital for additional information.

The Examination of Bone Marrow (Hematologic Series) — Youngstown Hospital Association, March 22.

Clinical and Radiological Aspects of Chronic Obstructive Pulmonary Disease — Trumbull Memorial Hospital, Warren; luncheon program, March 23; Gerald L. Baum, M.D., head Pulmonary Section B, Veterans Administration Hospital, Cleveland, and associate professor of medicine, Case Western Reserve University.

International Conference on Non-Ionizing Radiation Safety — at the Sheraton-Gibson Hotel, Cincinnati, March 29-31; under combined auspices of the U.S. Public Health Service, Bureau of Radiological Health, and the Laser Laboratory of the Medical Center, University of Cincinnati; contact: Laser Laboratory, Children's Hospital Research Foundation, Elland Avenue and Bethesda Avenue, Cincinnati 45229; (Followed by course on **The Applications of the Laser in Biology, Medicine and Dentistry,** April 1-3 — See under April.)

Infectious Diseases — Sponsored by Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus, March 31.

Updating Neurology — Cleveland Clinic Educational Institute, 2020 East 93rd Street, Cleveland 44106; March 31 - April 1; for specialists and nonspecialists.

April

The Applications of the Laser in Biology, Medicine and Dentistry, at the University of Cincinnati Medical Center, April 1-3; contact Leon Goldman, M.D., Laser Laboratory, Children's Hospital Research Foundation, Cincinnati 45229; or phone 513-281-6156 — Ext. 405. (This course follows the **International Conference on Non-Ionizing Radiation Safety** — See under March.)

Second Annual Sports Medicine Symposium —Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; April 5-6.

Fourth Annual Cancer Symposium — Sponsored by Ohio State University College of Medicine, at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus; April 7.

The Hemostatic Process (Hematologic Series) — Youngstown Hospital Association, April 11.

Symposium on Anesthesiology — Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland 44106; April 14-15.

Anesthesia Conference — Ohio State University College of Medicine, Columbus; at the OSU Center for Tomorrow, 2400 Olentangy River Road, Columbus; April 16.

Management of Graves Disease (Metabolic Series)—Youngstown Hospital Association, April 26.

Respiratory Failure — Trumbull Memorial Hospital, Warren; April 27.

Obituaries

Frederick William Andreas, M.D., Mentor; University of Michigan Medical School, 1920, aged 78; died October 26; member of the Ohio State Medical Association and the American Medical Association; former practitioner in Cleveland; chief of staff of the Polyclinic Hospital before his retirement in 1965; veteran of World War I; survived by a daughter, and a son, Dr. Bruce Andreas, of Mentor.

Sol David Braver, M.D., Akron; University of Tennessee College of Medicine, 1950; aged 50; died October 9; member of the Ohio State Medical Association, the American Medical Association, American Society of Plastic and Reconstructive Surgery, Society of Head and Neck Surgeons; Fellow of the American College of Surgeons; diplomate of the American Board of Plastic Surgery; practitioner in Akron for about nine years; served in the Army Medical Corps during the Korean Conflict; survived by his widow, two sons, a daughter, and his parents.

Isa Teed Cramton, M.D., Burton; Cleveland University of Medicine and Surgery, 1896; aged 94; died October 2; member of the Ohio State Medical Association and the American Medical Association; resident of long standing in Burton and practitioner there from 1899 to shortly after World War I; secretary of the Geauga County Medical Society for about 40 years. Her husband, Fred D. Cramton, died in 1942.

Russell Boyer Diley, M.D., Washington, D.C.; Ohio State University College of Medicine, 1946; aged 49; died October 2; former resident of Pickerington; resident training at Mt. Carmel Hospital, Columbus; practitioner in Washington for a number of years, specializing in radiology.

Clermont Justin Friedman, M.D., Cleveland; Western Reserve University School of Medicine, 1916; aged 78; died October 3; former member of the Ohio State Medical Association; practitioner in Cleveland for more than 50 years before his retirement in 1967; veteran of World War I; survived by a sister.

Harvey Furry Grazier, M.D., Richmond; University of Vermont College of Medicine, 1940; aged 53; died October 24 in a plane crash; member of the Ohio State Medical Association and the American Medical Association; general practitioner in the Jefferson County community and medical examiner for the Penn Central Railroad; veteran of World War II; survived by his widow, two sons, three daughters, a brother, and a sister.

Dimitri Krajewsky, M.D., Huntsville; medical degree from the University of Innsbruck, Austria, 1950; aged 48; died October 20; member of the Ohio State Medical Association, the American Medical Association, and the American Academy of General Practice; past president of the Logan County Medical Society; general practitioner in the Huntsville area since 1959; survived by his widow and two sons.

John Alfred Lukens, M.D., Toledo; University of Michigan Medical School, 1922; aged 72; died October 2; member of the Ohio State Medical Association, former member of the American Medical Association, member of the American Academy of Ophthalmology and Otolaryngology; Fellow of the American College of Surgeons; diplomate of the American Board of Otolaryngology; practitioner in Toledo for most of his professional career; survived by his widow, three daughters, and a sister.

Robert George McCready, M.D., Akron; Ohio State University College of Medicine, 1937; aged 61; died October 27; member of the Ohio State Medical Association, the American Medical Association, and American Urological Association; diplomate of the American Board of Urology; past president of the Summit County Medical Society; practitioner in Akron for 30 years; veteran of World War II; survived by his widow, four sons, and a brother.

Samuel Gaines Stubbins, M.D., Cleveland; State University of New York Downstate Medical Center, 1939; aged 57; died October 4; member of the Ohio State Medical Association, the American Medical Association, Clinical Orthopaedic Society; American Academy of Orthopaedic Surgeons, and the American Society for Surgery of the Hand; Fellow of the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery; practitioner in Cleveland for a number of years; veteran of World War II.

Joseph Szentendrey, M.D., Cleveland; medical degree from the University of Budapest, 1922; former member of the Ohio State Medical Association and the American Medical Association; practitioner in Hungary until he came to this country in 1949; general practitioner in Cleveland; retired in 1969; survived by his widow and two sons.

County-Community Activities

Promoters, 700 Strong, Back Youngstown Medical School

An audience of 700 persons in attendance at the medical school dinner, September 1, attested to the enthusiasm and support of the people of this area for a medical school, and to the work of a citizen's committee for the medical school at Youngstown.

The speaker was Dr. John D. Millett, chancellor of the Ohio Board of Regents, whose talk on the need for physicians and how Ohio might provide them was well received. Master of ceremonies, and chairman of the citizen's committee, was Harry Meshel, a former student of Dr. Millet. He did an outstanding job in guiding the meeting, just as he has done in leading the committee for the past year.

The size of the crowd and its enthusiasm was the big story as reported by the *Vindicator* and the TV and radio stations. Chancellor Millet was reported impressed, as were many visiting dignitaries, including representatives from Kent State, Akron State and Cleveland State Universities. The Medical Society was well represented by a large number of physicians and their wives in attendance. —Excerpt from the *Bulletin* of the Mahoning County Medical Society

Yesteryear Photo Quiz Featured in Montgomery County

The Montgomery County Medical Society's *Medical News* is running a series of illustrated human interest articles captioned "Can You Place the Face?"

Each article features a yesteryears photograph of one of the society's members, with the following lure: "The first physician (other than the subject) to call MCMS and properly identify the picture will be the Society's guest (free drinks, free meal) at the next regularly scheduled MCMS meeting."

Physician Assistants and the Doctor Shortage

As Dr. R. L. Kennedy, (Toledo and Lucas County) Academy President, pointed out in his discussion of this problem in the Bulletin last month, the proposal to endorse training programs in Ohio for physicians' assistants is being studied. This appears to us to be the best and fastest way to augment our medical manpower with people who are trained to handle limited aspects of patient care, under supervision of and with responsibility to physicians. We have accepted such assistants in the hospital, in the fields such as inhalation therapy and laboratory medicine, and we have even allowed nurses to learn to read electrocardiograms and to initiate treatment of cardiac and other emergencies! Why not utilize more assistants in the office or clinic, for history taking, for simpler details of the examination, and for record keeping? Trained assistants for routine procto-sigmoidoscopic examinations have been proposed in some quarters.

A system of triage, with nurse or assistant to sort out those who need only first aid, or treatment for minor illnesses, from those who need prompt major attention, is entirely feasible. Such assistants as we have now, are trained in schools of nursing, medical assistants' course, or in the doctor's office. But their potentialities would be more fully explored if they were trained in the medical colleges themselves, where a number of different limited courses could be taught. The assistants would be trained alongside the medical students, much as dental hygienists are trained in schools of dentistry. This would make them accepted members of the medical team from the start. Perhaps this is an opportunity to enlarge the enrollment and elevate the status of those few who are now in training as male nurses. —(Excerpt from the *Bulletin* of the Academy of Medicine of Toledo and Lucas County)

Columbus Academy Hears AMA Physician-Executive

The Academy of Medicine of Columbus and Franklin County was privileged to have as guest speaker at the October 20 dinner meeting, Dr. Richard S. Wilbur, Deputy Executive Vice-President of the American Medical Association. Following is a summary of Dr. Wilbur's talk, as written by Dr. Drew J. Arnold, Academy secretary-treasurer.

The title of Dr. Wilbur's address was "The New Look—American Medical Association." Dr. Wilbur stated that the doctors in this country definitely do need the AMA, mainly to help solve the biggest problem in the future—the problem

of compulsory national health insurance. He predicted that a national health insurance program will be passed through Congress some time—just before or just after the next presidential election. Dr. Wilbur discussed many other problems—problems of drugs, pollution, medical care for the poor and mental health. He stated that the health care industry is the largest in the world and that doctors, who used to compose 50 percent of the people in health care in the early 1900's, now compose only 7 percent of the people involved in health care. "A new look is needed," said Dr. Wilbur, "a new look retaining the old principles but with new techniques, dynamic planning, and a positive program."

In a recent survey, he stated, patients, more than anything else, want professional competence. One of the big problems is that the average person thinks the government can best solve problems and that doctors can easily retain their professional image but not in the planning of medical services.

The AMA is currently working on: (1) Health manpower (2) peer review, (3) someway to help people pay medical bills, (4) leadership in long range planning and development of programs for politicians to use, and (5) a positive approach in respect to TV, news, etc.

Dr. Wilbur stated that the AMA does not have all the answers by any means—that it needs the individual doctor, his time, his ideas, his money, and his leadership.

Mental Health Talk in Belmont County

The mental health program in Belmont County, functions of the board, and services available were discussed by Martha Van Meter, executive director of the Belmont County Mental Health Board, at the October 15 meeting of the Belmont County Medical Society. The program preceded the dinner meeting at the Belmont Hills County Club, and was attended by Auxiliary members.

Blue Shield Discussion Heard in Lorain County

The October 13th regular meeting of Lorain County Medical Society was held at Oberlin Inn. The attendance was 81, including three guests from Medical Mutual Inc., of Cleveland.

Following a brief business meeting, President Robert P. McFarland, M.D., introduced the Medical Mutual representatives, who presented slides outlining the Usual, Customary and Reasonable Fee Program. General discussion of questions pertaining to the program concluded the meeting.

True Consumer Control: The Right of Free Choice

Utilization of the resources of the AMA and the OSMA is indicated in the many situations where they can be of continuing help.

Response to our problems must be when and where they occur—"where the action is" at the local level. Our problems originate, are identified and must be resolved at the level of the county medical society. Our administration structure and individual thinking must be flexible enough to respond to the increasing demands on the physi-



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MEMBER: American Hospital Association — National Association of Private Psychiatric Hospitals — Ohio Hospital Association

cians as caretakers of the health as well as the illness of the community.

I feel we must move away from rigid positions and become more adaptable.

I am an exponent of the idea that what is best for the patient is what is best for the doctor. Our ability to innovate now will determine whether the patient will be afforded true freedom of choice in caring for his most important and vital asset, his health. Consumer control of the delivery of health care is agreed to be a desirable situation. There can be no more direct or responsive consumer control than the right of free choice of physician.

Delivery of health care under any less responsive relationship between the doctor and the patient offers serfdom to the physician and even greater loss of liberty to the patient. . . .

The doctor-patient relationship is an interpersonal relationship that cannot be short cut by the most complete computerized data and production line methods of delivery of health care. Possibly a mechanical minded administrator or economist could spray an "aerosol of compassion" on the "milk of human kindness" on the data processor or production line and add this essential ingredient. Compassion together with experience and the fact that people need people they can identify with in expressing their health needs demands continuing preservation of the doctor-patient relationship and freedom of choice of physician. . . . (Excerpt from an address given by Stephen P. Hogg, M.D., 1970-1971 President of the Academy of Medicine of Cincinnati at the academy's annual meeting in September. Quoted from the *Cincinnati Journal of Medicine,* October 1970.)

Lions Clubs Add Donation for Sight Saving

A gift of $14,800 has been given by the Ohio Lions Eye Research Foundation to support eye studies at the University of Cincinnati Medical Center.

Dr. Clifford G. Grulee Jr., dean of UC's College of Medicine, who accepted the gift from Edward Van Ness, of Cincinnati, Lions Foundation trustee, noted the valuable contributions made by the Lions clubs to research in vision. The Ohio foundation has raised money for eye research for 18 years. Its gifts to UC total $155,800.

The gift will be used to support the department's Eye Pathology Laboratory at Cincinnati General Hospital, major teaching hospital in the Medical Center.

ON THE OMPAC FRONT

High Party Leaders Urge Physicians to Get Into Politics

In a recent issue of *Political Stethoscope*, published by the American Medical Political Action Committee, there appeared statements by the national chairmen of the Democratic and Republican parties which are directed specifically at physicians and their wives.

Wrote Lawrence F. O'Brien, Democratic chairman, in part: "I am very pleased to endorse the efforts of *Political Stethoscope* in urging physicians and their wives to play a more active role in politics. Of course, I would urge anyone to play as full a role as possible in public affairs and in the political activity of their community, because the genius of our political system is demonstrated best when there is widespread interest on the part of the electorate.

"I would particularly urge physicians on to greater activity, though, because as professional men they offer a unique combination of educational background and high public esteem that makes them ideal for political judgment and political work."

Comments of Rogers C.B. Morton, Republican chairman, were in part: "Political apathy is like a tumor left too long unattended. It continues to grow and destroys the entire system. It will eventually destroy our democratic way of life, for if the majority is apathetic, then we will have 'minority rule'. If this trend continues, ***millions of Americans will find that someone else will have made the choice for them.

"I particularly appeal to physicians and their wives to give politics that booster shot it so badly needs***Your lives, both professionally and socially, are drastically affected by how Washington and your own State Capitol move, and you cannot leave it solely to the lobbyists to influence the direction it takes."

While these political experts did not say so in so many words, the implication is there: Politics is a round-the-clock activity, 12 months in every year. One week, one month, one year of apathy on the part of those who have a big stake in what happens in officialdome can be fatal. The coming year—1971—is a vital time when getting ready for the big political battles in 1972 must have top priority. Keep OMPAC strong by making your annual $25 contribution through your local medical society secretary promptly. —*Ohio Medical Political Action Committee*

Woman's Auxiliary Highlights . . .

Mrs. Robert E. Krone, State Publicity Chairman
4755 Miami Road, Cincinnati, Ohio 45243

IT WOULD BE GREAT to have wings—to be able to fly from one city to another and bring you a first hand report of all the current activities of our county auxiliaries. There have been many interesting meetings held and numerous worthwhile projects launched or continuing. Here are a few of the details from my mail box.

Lucas County

The Bulletin of the Academy of Medicine of Toledo and Lucas County contains a couple of pages each month for auxilians. Headed by a note from the president, Mrs. Brian Bradford, the news includes a calendar of events, a description of activities for members and brief committee reports. This method of communicating through your medical society publication might be tried by county auxiliaries not currently circulating a monthly newsletter.

Lucas County offers an interesting choice of study groups for its members: Beauty through Ballet, Investment Group, Gourmet Group, Art, Ceramics, Antiques, Gardening, Swimming, and Bridge. A bridge marathon is underway as the chief Ways and Means project of the year. Policewoman Jeanne Bray of the Columbus Police Department was the speaker at the November meeting, which doubled as a Fourth District meeting.

Columbiana County

Mrs. Henry Holden, state community health chairman, was the guest speaker for the October meeting of the auxiliary in Columbiana. Her timely topic was "Tips to Take Home to the Family." Proceeds from a bazaar held in November will benefit the Robert Bycroft School for retarded children.

A two week strike at the East Liverpool City Hospital was hindering the care of patients. Mrs. Janis Lauva, president, Columbiana County Auxiliary, called upon the wives of the hospital staff doctors to contribute their services during this emergency. They responded with a round-the-clock shift, even helping in the laundry, kitchen and wherever needed. The strike is now settled, the employees are back to work, and the doctors are very proud of their wives!

From Stark County's Capsule Newsletter

The November meeting of the Stark County Auxiliary was a luncheon and fashion show at the Imperial House with styles by Halle's. The Scholarship Loan Committee reported that $7,243.00 has been loaned this year to ten students at Mercy Hospital, Aultman Hospital and the University of Cincinnati. Payments by girls through school are coming in but the fund needs replenishing. A benefit dance is scheduled soon.

Mrs. R. A. Feezel, publicity chairman, proudly reports that the Auxiliary has donated $1340.00 to supply a room in the Canton Art Institute section of the new Cultural Center. This room will consist of "Touch Me" exhibits of artifacts and materials of other lands, plus looms on which they were made so that the children can learn

THE WOMAN'S AUXILIARY TO THE OHIO STATE MEDICAL ASSOCIATION

President
Mrs. Carl F. Goll
1001 Granard Parkway
Steubenville, 43952

President-Elect
Mrs. Russell L. Wiessinger
2280 W. Wayne Street
Lima, 45805

Past President
Mrs. Samuel L. Meltzer
2442 Dorman Drive
Portsmouth, 45662

First Vice-President
Mrs. Rudolf O. Cooks
15830 Van Aken Blvd., Apt. 401
Cleveland, 44120

Second Vice-President
Mrs. Daniel Wolff
3963 W. Bancroft Street
Toledo, 43606

Third Vice-President
Mrs. H. I. Humphrey
389 S. Drexel Avenue
Columbus, 43209

Recording Secretary
Mrs. Emil L. Barrows
7181 W. Aracoma Drive
Cincinnati, 45237

Corresponding Secretary
Mrs. F. A. Sunseri
301 Woodridge Drive
Steubenville, 43952

Treasurer
Mrs. Paul Hahn
122 Moore Avenue, N.W.
New Philadelphia, 44663

first hand of their operation. This is one example of how auxiliaries can contribute more to the communities of which they are a part.

Summit County Considers Mobile Meals

Auxilians from Akron visited Toledo in September to see the operation of the Mobile Meals Project. Then Mrs. Howard E. Smith and Mrs. Daniel A. Wolff, of Toledo, discussed the project at the October meeting of the Summit County Auxiliary. Hostesses for this luncheon, which was held in Peninsula, Ohio, were Mrs. Vincent Dattilo and Mrs. Otto N. Bernath. The president, Mrs. Earl Hershberger, conducted a brief business meeting.

Cuyahoga County Reports

To open the thirtieth year of the Woman's Auxiliary to the Academy of Medicine of Cleveland, Mrs. Thomas L. Manning, president, invited auxiliary members from five counties to a "President's Brunch" at LaPlace Restaurant. Special recognition was given new members who each received a chrysanthemum, traditional flower of the auxiliary.

A psychiatrist, Mildred Hickey Shelly, M.D., discussed "The Mature Woman and Her Role Today." She stated that middle-aged people are in a powerful position today. "They manage most of the affairs of the world. They are the decision-makers." Quoting further from the excellent news story: "Women, especially, don't realize the power of maturity. A tremendous amount of money and research is spent on the young and the aged, but the middle-agers are so successful that no federal agency is devoted to them."

Dr. Shelly stated that the middle-aged woman is meeting many changes—physical, psychological and environmental—that the cessation of the menses reminds her that her service to the species has come to an end—she is entering a different phase of existence. "Her life can now be filled destructively or constructively. She may try to continue living through her children, but children have their own lives to lead."

"At middle age, many of us find that our personal environment has changed. We now have the position and the possessions for which we struggled in earlier years. Can we sit back and rest? Not for one moment. We must be part of the change."

Dr. Shelly suggested that the mature woman can communicate on a new level with her friends —conversation is no longer concerned with children and housekeeping problems but ranges world-wide. "For the middle-aged woman there are two generation gaps; she is between them and can build bridges."

Proceedings of The Council

A meeting of The Council of the Ohio State Medical Association was held by telephone conference at 2 p.m., October 9, 1970. Those present were Drs. Fulton, Robechek, Smith, Henry, Ivins, Becker, Wells, Clarke, McLarnan and Messrs. Page and Edgar.

Dr. Fulton called the meeting to order and explained that Federal legislation requiring Medicare and Medicaid peer review organization would probably pass during the current session of Congress.

Mr. Edgar reviewed the latest information from the AMA Washington office, which indicated that legislation would probably require a statewide prime contractor as a professional service review organization.

The Council discussed the matter and voted that the Ohio State Medical Association apply for the position of prime contractor, working with the county medical societies.

The staff was instructed to proceed with the drafting of the organization plan and the application for the contract.

ATTEST: Hart F. Page
Executive Director

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County Societies' Officers and Meeting Dates

First District

Councilor: Paul N. Ivins, Hamilton 45011
306 High St.

ADAMS—Gary J. Greenlee, President, Farmers' Bank Building, Manchester 45144; Hazel Sproull, Secretary. P.O. Box 337, West Union 45693, 3rd Thursday. April, July, Oct. and Jan.

BROWN—Robert S. Benintendi, President, South Main Street, Route 1, Box N, Georgetown 45121; Robert A. Baker, Secretary, South Main Street, Georgetown 45121.

BUTLER—Robert M. Kappers, President, 1101 Western Ave., Hamilton 45013; Mr. E. Clifford Roberts, Executive Secretary, P.O. Box 325, 110 North Third St., Hamilton 45011. 4th Wednesday.

CLERMONT—Kurt Platschik, President, 4450 Mt. Carmel-Tobasco Road, Cincinnati 45244; Carl A. Minning, Secretary, 2548 Williamsburg Pike, Batavia 45103; 3rd Wednesday except July, August and December.

CLINTON—Arthur F. Lippert, President, 110 East Locust St., Wilmington 45177; Mary R. Boyd, Secretary, Box 629, Wilmington 45177. 4th Tuesday.

HAMILTON—Stephen P. Hogg, President, 250 Wm. H. Taft Road, Cincinnati 45219; Mr. Edward F. Willenborg, Executive Secretary, 320 Broadway, Cincinnati 45202. 3rd Tuesday, Sept., Nov., Jan., Feb., April & May 23, 1971.

HIGHLAND—Thomas L. Jones, President, 528 South St., Greenfield 45123; Glenn B. Doan, Secretary, 614 Jefferson St., Greenfield 45123.

WARREN—Thomas E. Fox, President, 309 Reading Rd., Mason 45040; Orville L. Layman, Secretary, 22 West Fourth St., Franklin 45005. 2nd Tuesday.

Second District

Councilor: George J. Schroer, Ft. Loramie 45845
20 S. Main St.

CHAMPAIGN—Lewis Inskeep, President, 201 Scioto St., Urbana 43078; Terrence F. Grogan, Secretary, 848 Scioto St., Urbana 43708. 2nd Wednesday.

CLARK—Wesley E. Knaup, President, 1054 East High St., Springfield 45505; Mrs. Marion Wilcoxson, Executive Secretary, 616 Building, Room 131, 616 North Limestone St., Springfield 45503. 3rd Monday, except June, July, Aug. and Dec.

DARKE—E. W. Browne, President, 330½ West Fourth Street, Greenville 45331; 3rd Tuesday.

GREENE—Rudi Sotlar, President, 12 South Limestone Street, Jamestown 45335; Mrs. W. F. Whitt, Executive Secretary, 966 Whitestone St., Xenia 45385. Last Friday of every month.

MIAMI COUNTY—Kenneth Faze, President, 3 Duerr Drive, West Milton 45383; Martha L. Derr, Executive Secretary, P.O. Box 467, Piqua 45356. 1st Tuesday.

MONTGOMERY—Robert A. Bruce, President, 1126 South Main St., Dayton 45409; Mr. Earl Shelton, Executive Secretary, 280 Fidelity Medical Building. Dayton 45402. Monthly meeting dates as established.

PREBLE—J. D. Darrow, President, 228 North Barron St., Eaton 45320; J. R. Williams, Secretary, 228 North Barron St., Eaton 45320. No regular meeting date.

SHELBY—George J. Schroer, President, 20 South Main St., Fort Loramie 45845; William F. Mentges, Secretary, 870 South Main Ave., Sidney 45365. 2nd Tuesday of March, June, September and December.

Third District

Councilor: Dwight L. Becker, Lima 45805
1559 Bunker Drive

ALLEN—Alexander C. Reed, President, 819 West North St., Lima 45801; William E. Noble, Secretary, c/o Memorial Hospital, Linden & Mobel Ave., Lima 45804. 3rd Tuesday.

AUGLAIZE—John F. Bowling, President, 1001 Knoxville Rd., St. Marys 45885; Barbara Cummins, Secretary, 310 Perry St., Wapakoneta 45895. 1st Thursday every other month, starting with January.

CRAWFORD—Horace B. Newhard, President, 140 Hill St., Bucyrus 44820. Meeting date variable.

HANCOCK—Robert Brown, President, 868 South Main St., Findlay 45840; Truman S. Smith, Secretary, 145 West Wallace St., Findlay 45840. 1st Tuesday monthly.

HARDIN—Jay Pfeiffer, President, 215 Main St., Kenton 43326; John Hughes, Secretary, 601 Pattison Ave., Kenton 43326. 2nd Tuesday evening monthly.

LOGAN—Donald Wyse, President, Oakhill Medical Association, West Liberty 43357; Douglas W. Beach, Secretary, 1008 North Main St., Bellefontaine 43311. 1st Friday monthly.

MARION—John E. Aiken, President, 1040 Delaware Ave., Marion 43302; Brooks Sitterly, Secretary, McKinley Parkway Dr., Marion 43302. 1st Tuesday monthly.

MERCER—George H. McIlroy, President, 123 East Fayette St., Celina 45822; D. J. Schwieterman, Secretary, Maria Stein 45860. 3rd Thursday.

SENECA—Leroy Cummings, President, 455 W. Market St., Tiffin 44883; Donald Shanabrook, Secretary, 455 West Market St., Tiffin 44883. 3rd Tuesday evening Jan., March, May, July, Sept. and Nov.

VAN WERT—Thomas R. Wilson, President, Van Wert County Hospital, Van Wert 45891; Robert Scheidt, Secretary, Medical Arts Building, Van Wert 45891. 4th Friday.

WYANDOT—D. P. Smith, President, Pennington St., Sycamore 44882; K. K. Solacoff, Secretary, 777 North Sandusky Avenue, Upper Sandusky 43351. 2nd Tuesday.

Fourth District

Councilor: George N. Bates, Toledo 43624
316 Michigan St.

DEFIANCE—Jack A. Kane, President, Central Foundry, Defiance 43512; Miss Lois Coffin, Executive Secretary, Defiance Hospital, Defiance 43512. 1st Saturday.

FULTON—R. L. Davis, President, 137 South Fulton St., Wauseon 43567; M. S. Renfrew, Secretary, 494 Shoop Ave., Wauseon 43567. Quarterly meetings March, June, Sept. and Dec.

County Society Roster (continued)

HENRY—T. F. Moriarty, President, 651 Strong St., Napoleon 43545.

LUCAS—Roland L. Kennedy, President, 4639 Farmington Rd., Toledo 43623; Mr. Robert W. Elwell, Executive Secretary, 3101 Collingwood Blvd., Toledo 43610. 3rd Tuesday.

OTTAWA—Donald F. Loeffler, President, 521 East Second St., Port Clinton 43452; Gordon R. Ley, Secretary, P. O. Box J, Port Clinton 43452. 2nd Thursday evening monthly.

PAULDING—Kirkwood A. Pritchard, President, 119 South Main St., Paulding 45879; Don K. Snyder, Route #2, Paulding 45879. 3rd Monday monthly at the Paulding County Memorial Hospital.

PUTNAM—James B. Overmier, President, 109 Main St., Leipsic 45856; Arthur P. Daniel, Secretary, 144 North Walnut St., Ottawa 45875. 1st Tuesday.

SANDUSKY—W. W. Randolph, Jr., Acting Secretary, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Askins, Executive Secretary, Central Office, Memorial Hospital of Sandusky County, Fremont 43420. 3rd Wednesday except June, July, and August.

WILLIAMS—P. G. Meckstroth, President, Central Drive, Bryan 43506; S. O. Cooper, Secretary, Central Drive, Bryan 43506. 3rd Tuesday.

WOOD—William Roberts, President, North Baltimore 45872; William F. Lord, Secretary, 950 West Wooster St., Bowling Green 43402. 3rd Thursday monthly.

Fifth District

Councilor: David Fishman, Cleveland 44106
10515 Carnegie Avenue

ASHTABULA—W. B. Millberg, President, 430 West 25th Street, Ashtabula 44004; Mrs. Donna L. Miggo, Executive Secretary, P.O. Box 1772, Ashtabula 44004. 2nd Tuesday.

CUYAHOGA—Vincent T. LaMaida, President, 4125 Mayfield Rd., Cleveland 44121; Mr. Robert A. Lang, Executive Secretary, 10525 Carnegie Ave., Cleveland 44106. Board meets 2nd Tuesday.

GEAUGA—Oscar Brinckmann, President, 12475 Hospital Dr., Chardon 44024; Mrs. Ruth Milgate, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024. 2nd Friday.

LAKE—John J. Cahill, President, 36001 Euclid Ave., Willoughby 44094; Mrs. Owen A. McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060. 4th Wednesday of Jan., March, May, Sept. and Nov.

Sixth District

Councilor: Maurice F. Lieber, Canton 44703
515 Third St., N. W.

COLUMBIANA—John A. Fraser, President, 403 Little Building, East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 193 Park Ave., Salem 44460. 3rd Tuesday monthly.

MAHONING—Robert L. Jenkins, Jr., President, 21 Wickliffe Circle, Youngstown 44515; Mr. Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Building, 1005 Belmont Avenue, Youngstown 44505. 3rd Tuesday, except June, July and August.

PORTAGE—Kenneth F. Rupp, President, 9160 State Route 43, Streetsboro 44240; Miss Marie Motyka, Executive Secretary, 430 Grant St., Akron 44311. 3rd. Tuesday.

STARK—Frank O. Goodnough, Room 615, President, Peoples-Merchants Trust Building, Massillon 44646; Mr. J. H. Austin, Executive Secretary, 405 4th Street, N. W., Canton 44702. 2nd Thursday.

SUMMIT—Edwin W. Cauffield, President, 505 Ohio Building, Akron 44308; Mr. S. H. Mountcastle, Executive Secretary, 430 Grant Street, Akron 44311. 2nd Tuesday, excluding July and August.

TRUMBULL—J. R. Phillips, President, St. Joseph's Hospital, N. Tod Avenue, Warren 44485; Mrs. Kay Ticknor, Executive Secretary, 280 North Park Avenue, Warren 44481. 3rd Wednesday, September through May

Seventh District

Councilor: Sanford Press, Steubenville 43952
525 North Fourth St.

BELMONT—Thomas L. Ring, President, 3205 Belmont Street, Bellaire 43906; Bertha M. Joseph, Secretary 100 South 4th Street, Martins Ferry 43935. 3rd Thursday, except January, May, July and August.

CARROLL—T. J. Atchison, President, 292 East Main St., Carrollton 44615; Jack L. Maffett, Secretary, 264 South Lisbon St., Carrollton 44615. 3rd Tuesday.

COSHOCTON—Myron Saturski, President, 149 South Bridge Street, Newcomerstown 43832; Robert W. Secrest, Secretary, 1926 Melbourne Road, Coshocton 43812. 2nd Tuesday.

HARRISON—R. W. Weiser, President, Jewett 43986; Janis Trupovnicks, Secretary, Hopedale 43976. Quarterly, March, June, Sept. and Dec.

JEFFERSON—Crist G. Strovilas, President, 812 North Fourth St., Toronto 43964; Mrs. Mary Freedman, Corresponding Secretary, P.O. Box 655, Steubenville 43952. 4th Tuesday, except Aug. and Dec.

MONROE—Byron Gillespie, Secretary, Woodsfield 43793.

TUSCARAWAS—P. T. Doughten, President, 551 Wabash Ave. N. W., New Philadelphia 44663; M. R. Puterbaugh, Secretary, 104 Iron Ave., Dover 44622.

Eighth District

Councilor: William M. Wells, Newark 43055
241 Hudson Street

ATHENS—Dale Mattmiller, President, Hudson Health Center, Athens 45701; L. A. Hamilton, Secretary, 400 East State Street, Athens 45701. Second Tuesday quarterly, September, December, March, and June.

FAIRFIELD—R. A. Welsh, President, Lancaster-Fairfield Hospital, Lancaster 43130; C. R. Reed, Secretary, 309 East Main Street, Lancaster 43130. 2nd Tuesday.

GUERNSEY—Merritt C. McCuskey, President, 1200 Edgeworth Ave., Cambridge 43725; Quentin F. Knauer, Secretary, 100 Clark Ct., Cambridge 43725. 1st Tuesday monthly, 7 P.M., Cambridge Country Club.

LICKING—Edward A. Carlin, President, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055; G. Franklin Gabe, Secretary, Moundbuilders Doctors Park, 1272 West Main St., Newark 43055. 4th Tuesday monthly.

MORGAN—Asa Whitacre, President, Chesterhill 43728; Henry Bachman, Secretary, 426 East Union Ave., McConnelsville 43756.

MUSKINGUM—James F. Morton, President, 727 Market St., Zanesville 43701; Myron H. Powelson, Secretary, 2825 Maple Ave., Zanesville 43701. 1st Tuesday.

NOBLE—Frederick M. Cox, President, Caldwell 43724; Edward G. Ditch, Secretary, Box 239, Caldwell 43724. 1st Tuesday.

County Society Roster (continued)

PERRY—A. G. Cruz, President, 203 North Main St., New Lexington 43764; R. E. Herendeen, Jr., 203 North Main St., New Lexington 43764.

WASHINGTON—Gregory B. Krivchenia, President, 326 Third St., Marietta 45750; Donald E. Fleming, Secretary, Vincent 45784. 2nd Wednesday monthly.

Ninth District

Councilor: Oscar W. Clarke, Gallipolis 45631
4th & Sycamore St.

GALLIA—Arturo de Lamerens, President, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631; Donald M. Thaler, Secretary, The Holzer Medical Center, First and Cedar Sts., Gallipolis 45631. Quarterly meetings at call of officers.

HOCKING—Lethia W. Starr, President, 109 Mulberry St., Logan 43138; J. W. Doering, Secretary, 42 North Spring St., Logan 43138. 2nd Tuesday monthly.

JACKSON—Earl Levine, President, 120 North Ohio Avenue, Wellston 45692; John M. Cook, Secretary, Box 316, Oak Hill 45656. Meetings when called.

LAWRENCE—A. Burton Payne, President, 411 Center Street, Ironton 45638; George Newton Spears, Secretary, 2213 South Ninth Street, Ironton 45638. Quarterly meetings.

MEIGS—Charles J. Mullen, President, 210½ East Main St., Pomeroy 45769; E. Butrimas, Secretary, 204 East Main St., Pomeroy 45769.

PIKE—W. W. Wiltberger, President, 330 East North St., Waverly 45690; Thomas Hwang, Secretary, 300 Cherry St., Waverly 45690. 1st Tuesday monthly.

SCIOTO—Joseph T. Gohmann, President, c/o Scioto County Medical Society, 1805 27th St., Portsmouth 45662; Mr. Lowell Thompson, Executive Secretary, 1805 27th St., Portsmouth 45662. 6:30 p.m. 2nd Tuesday.

VINTON—Richard E. Bullock, President, 203 South Market St., McArthur 45651.

Tenth District

Councilor: James C. McLarnan, Mt. Vernon 43050
104 E. Gambier St.

DELAWARE—John L. Binkhorst, President, 26 Northwood Dr., Delaware 43015; Lloyd E. Moore, Secretary, Magnetic Springs 43036. 3rd Tuesday except June, July and Aug.

FAYETTE—H. W. Payton, President, 36 South Main Street, Jeffersonville 43163; M. H. Roszmann, Secretary, 1005 East Temple Street, Washington C. H. 43160. 2nd Friday.

FRANKLIN—Philip H. Taylor, President, 3545 Olentangy River Rd., Columbus 43214; Mr. W. "Bill" Webb, Executive Secretary, 17 South High St., Suite 528, Columbus 43215. 3rd Tuesday except June, July and Aug.

KNOX—James R. McCann, President, Medical Arts Building, Mount Vernon 43050; Robert Westerheide, Secretary, Medical Arts Building, Mount Vernon 43050. 1st Wednesday.

MADISON—Brawley Arikawa, President, 176 North Madison Road, London 43140; William T. Bacon, Secretary, 194 Elm Street, London 43140. Four times a year, 2nd Wednesday (3, 6, 9, 12).

MORROW—David James Hickson, President, 712 Baker St., Mount Gilead 43338; Lowell Murphy, Secretary, 209 South Main St., Cardington 43315. 1st Tuesday monthly.

PICKAWAY—H. H. Swope, President, 400 North Court St., Circleville 43113; Carlos Alvarez, Secretary, 147 Pinckney St., Circleville 43113. 1st Tuesday except July and Aug.

ROSS—Roy Manning, President, 1 Overlook Dr., Chillicothe 45601; Paul MacCarter, Secretary, 60 Central Center, Chillicothe 45601. 1st Thursday.

UNION—John R. Linscott, President, 225 Stockdale Dr., Marysville 43040; May B. Zaugg, Secretary, Route 5, Timber Trails, Marysville 43040. 1st Tuesday of Feb., April, Oct. and Nov.

Eleventh District

Councilor: William R. Schultz, Wooster 44691
1749 Cleveland Rd.

ASHLAND—William Emery, President, 247 Sandusky Street, Ashland 44805; J. H. Cooperrider, Secretary, 637 North Union Street, Loudonville 44842. 1st Thursday.

ERIE—R. H. Williamson, President, 410 Wasta Rd., Huron 44839; Mrs. Barbara Wolfert, Executive Secretary, 1428 Hollyrood Rd., Sandusky 44870. 2nd Tuesday except July and Aug.

HOLMES—Daniel J. Miller, President, Walnut Creek 44687; Charles H. Hart, Secretary, 109 South Clay St., Millersburg 44654. First (or Second) Thursday 7 P.M. (Sometimes it may follow hospital staff meeting.)

HURON—John E. Rosso, President, 218 Myrtle Ave, Willard 44890; Russell R. Fisher, Secretary, 257 Benedict Ave., Norwalk 44857. 2nd Wednesday of February, April, June, October and December.

LORAIN—Robert P. McFarland, President, Oberlin Clinic, Inc., 224 West Lorain Street, Oberlin 44074; Mrs. Gladys Davidson, Executive Secretary, 428 West Avenue, Elyria 44035. 2nd Tuesday for REGULAR MEETINGS. Last Thursday of the month for COUNCIL MEETINGS.

MEDINA—H. E. Grover, President, 146 North Lyman Street, Wadsworth 44281; Mr. A. Dana Whipple, Executive Secretary, 943 N. Jefferson Street, Medina 44256. 3rd Thursday.

RICHLAND—Robert W. Jones, President, 120 Sturges Avenue, Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, c/o Mansfield General Hospital, Mansfield 44903. 3rd Thursday except June, July and August.

WAYNE—Frank Cebul, President, 1740 Cleveland Road, Wooster 44691; Thomas Graves, Secretary, 1740 Cleveland Road, Wooster 44691. 2nd Wednesday of alternate months.

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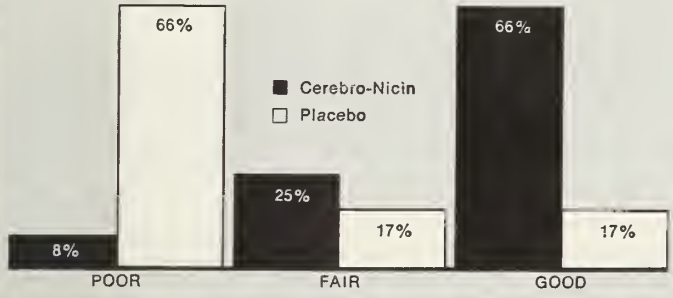
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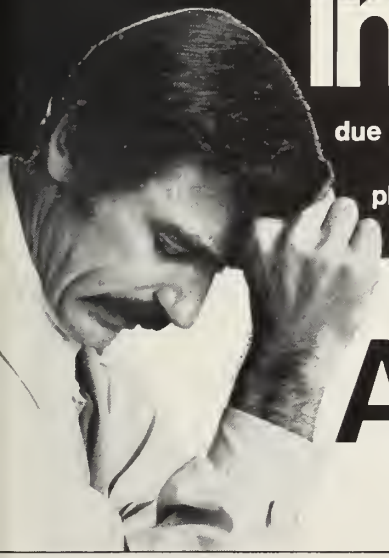
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Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone Thyroid is not to be used in heart disease and hypertension.

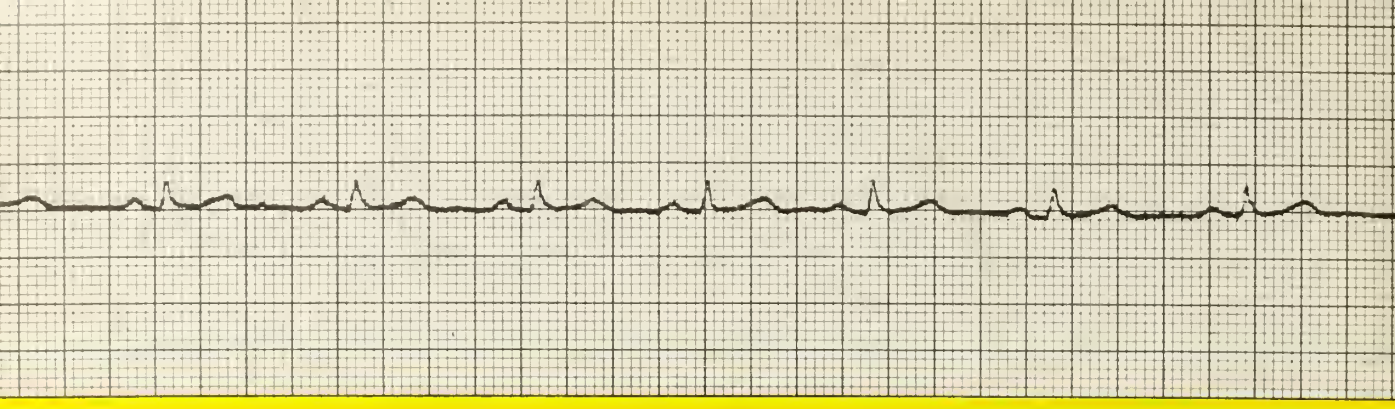
Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.
Hypercalcemia may occur, particularly in immobilized patients use of Testosterone should be discontinued as soon as hypercalcemia is detected

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence Clin Med 12 69, 1966 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound West Med 5 67, 1964 3. **Titett, A. S** Methyltestosterone-thyroid in treating impotence, Gen Prac 25 6, 1962 4. **Heliman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19 936, 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79 863, 1958 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp 79-99.

rite for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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